CHILD REGISTRATION FORM

Name of Child: ________________________ Birth Date: ______________ Sex: ______

Address/Zip Code: ____

Child's Start Date: ______________ Child's End Date: ______________

Registering Parent/Guardian:

Name: ________________________

Address: ________________________

Phone Number: ________________________

Name of Employer: ________________________

Work Number: ________________________

Work Address: ________________________

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City State Zip

Spouse/Parent:

Name: ________________________

Address: ________________________

Phone Number: ________________________

Name of Employer: ________________________

Work Number: ________________________

Work Address: ________________________

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City State Zip

Parents Marital Status:

Single Married
Widowed Divorced
Separated

Ages of Siblings

Race:

Afro. Amer. Asian Amer.
Native Amer. Latin Amer.
Euro. Amer. Other
(Please write

OTHER PERSON TO NOTIFY IF PERSON PLACING THE CHILD CANNOT BE REACHED:

Name: ________________________

Phone Number: ________________________

Address: ________________________

Relationship: ________________________

PHYSICIAN TO CALL IF CHILD BECOMES ILL OR INJURED:

Name: ________________________

Phone Number: ________________________

Address: ________________________

Hospital or Clinic: ________________________

PROGRAM:

Days per week: ________________________

Hours of Care: ________________________

Rate of Pay: ________________________

Signature of Parent/Guardian Signature of Caregiver