

ROARING FORK KIDS
MEDICAL/REGISTRATION INFORMATION
REQUIRED for CHILDCARE ENROLLMENT

This form needs to be signed by a physician and returned with a copy of your child's immunizations by or on the day your child starts.

Child's Full Name: _____ Birthday: ____/____/____

Address: _____ Phone: _____

Parents: Married: ____ Single: ____ Separated: ____ Divorced: ____ Widow (er) ____

Mother's Name: _____ Father's Name: _____

Mother's Address: _____ Father's Address: _____

Mother's phone numbers: W _____

Father's phone numbers: W _____

H _____

H _____

C _____

C _____

Mother's fax: _____

Father's fax: _____

E-mail address: _____

E-mail address: _____

Mother's occupation: _____

Father's occupation: _____

Mother's employer: _____

Father's employer: _____

People other than a parent to be notified in an emergency if a parent is not available.

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

People other than parents who are authorized to pick up this child:

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

Please name and describe people who are not allowed to pick up your child.

I give permission for staff to assist my child, in an emergency situation, in any way needed.

Yes _____ No _____

I give permission for staff to put on their sunscreen if the weather warrants it. Yes ___ No ___

I give permission for staff to use diaper creams and ointments if my child needs it. Yes ___ No ___

I give permission for staff to take my child on field trips walking and/or taking public transportation.
Yes ___ No ___

I give permission for staff to show educational/appropriate movies on very rare occasions.

Yes ___ No ___

Parent's Signature: _____ Date: _____

Please complete the brief medical history below.

Allergies: _____

Surgery/Accidents/Serious Illness/Chronic Medical Condition:

Physical or emotional condition that may require special attention by staff:

Current Medication: _____

Condition Medication is for: _____

Physician's Name: _____ Phone: _____

X _____ Date: _____

Signature of licensed physician or nurse practitioner.

Health Insurance Company: _____ Phone: _____

Dentist's Name: _____ Phone: _____

Please request that your doctor's office record your child's immunizations and dates administered on a Certificate of Immunization and write a letter of good health for your child and return it with this form.