



**CHILD CARE  
REGISTRATION FORM**

DATE CHILD ENTERED CARE	DATE CHILD LEF CARE
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CHILD'S NAME LAST                      FIRST                      MIDDLE                      NAME USED	BIRTHDATE
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STREET ADDRESS	CITY	ZIP CODE
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CHILD'S PARENT/GUARDIAN'S NAME	HOME TELEPHONE NUMBER (AND AREA CODE)	WORK TELPHONE NUMBER (AND AREA CODE)
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STREET ADDRESS	CITY	ZIP CODE
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WORK ADDRESS (OR WHERE YOU CAN BE REACHED WHILD CHILD IS IN CARE)	CITY	ZIP CODE
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CHILD'S PARENT/GUARDIAN'S NAME	HOME TELEPHONE NUMBER (AND AREA CODE)	WORK TELPHONE NUMBER (AND AREA CODE)
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STREET ADDRESS	CITY	ZIP CODE
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WORK ADDRESS (OR WHERE YOU CAN BE REACHED WHILD CHILD IS IN CARE)	CITY	ZIP CODE
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**OTHER PEOPLE TO NOTIFY IN CASE OF EMERGENCY**

NAME	ADDRESS	TELEPHONE NUMBER
Relationship:		Work: Home:
Relationship:		Work: Home:
Relationship:		Work: Home:
Relationship:		Work: Home:

**OTHER THAN YOU, WHO HAS PERMISSION TO PICK UP YOUR CHILD?**

NAME	ADDRESS	TELEPHONE NUMBER
		Work: Home:
		Work: Home:
		Work: Home:

**WHO DOES NOT HAVE PERMISSION TO PICK UP YOUR CHILD?**

NAME	REASON

CHILD'S HEALTH INFORMATION			
DATE OF CHILD'S LAST PHYSICAL EXAMINATION:	CHILD'S HEALTH CARE PROVIDER'S NAME	TELEPHONE NUMBER (AND AREA CODE)	
STREET ADDRESS		CITY	ZIP CODE
SPECIAL HEALTH PROBLEMS		ALLEGIES, INCLUDING DRUG REACTIONS	
REGULAR MEDICATIONS		OTHER PERTINENT DATA	
CHILD'S DENTIST'S NAME		TELEPHONE NUMBER (AND AREA CODE)	
STREET ADDRESS		CITY	ZIP CODE
CHILD'S MEDICAL INSURANCE COVERAGE			
INSURANCE COMPANY'S NAME		MEMBER/POLICY NUMBER	
POLICY HOLDER'S NAME		EMPLOYER'S NAME	
INSURANCE COMPANY'S NAME		MEMBER/POLICY NUMBER	
POLICY HOLDER'S NAME		EMPLOYER'S NAME	
CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR CHILDREN			
<p>I hereby give permission that my child, _____,</p> <p>may be given emergency treatment by a qualified child care provider at</p> <p>_____</p> <p style="text-align: center;">NAME AND/OR ADDRESS</p> <p>When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health. I waive my right of informed consent to such treatment.</p> <p>I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.</p> <p>I certify (or declare) under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.</p>			
PARENT/GUARDIAN'S SIGNATURE		DATE	PARENT/GUARDIAN'S SIGNATURE
			DATE
STREET ADDRESS		CITY	ZIP CODE
			TELEPHONE NUMBER (AND AREA CODE)