

⌘ CHILDREN'S ENROLLMENT RECORD

Date of Enrollment _____

⌘ Child's Name _____ Nickname _____

Home Address _____

Home Phone _____ Sex: M F Age _____ Date of Birth _____

Family Members: _____

⌘ Mother or Guardian's Name _____

Address if different from child's _____

Home Phone _____ Cell Phone _____ Email _____

Name of employment _____ Work Phone _____

Address of employment _____

⌘ Father or Guardian's Name _____

Address if different from child's _____

Home Phone _____ Cell Phone _____ Email _____

Name of employment _____ Work Phone _____

Address of employment _____

⌘ Special instructions for reaching parent or guardian

⌘ EMERGENCY CONTACTS

1. Name _____
Home Phone _____
Address _____
Work Phone _____ Relationship to child _____
2. Name _____
Home Phone _____
Address _____
Work Phone _____ Relationship to child _____

⌘ CHILD PICK UP INFORMATION

Persons authorized to pick up your child
(Must show photo ID)

- Name _____
Home Phone _____ Work Phone _____
- Name _____
Home Phone _____ Work Phone _____
- Name _____
Home Phone _____ Work Phone _____

⌘ General Information about Child

- Habits: _____
Eating Behaviors: _____
Sleeping Pattern: _____
Fears: _____
Likes/ Dislikes: _____
Other: _____

⌘ Medical Information

⌘ Name, address and phone number of child's doctor _____

⌘ Hospital of Preference (Please check one)

Memorial Hospital
719-365-5000

Penrose Hospital
719-776-5000

Evans Army Community Hospital
719-526-7000

Other _____

⌘ Chronic Medial conditions _____

⌘ Is your child fully immunized? Yes No

(Completed immunization records must be provided on or before the first day the child is in care.)

⌘ Food Allergies _____

⌘ HEALTH HISTORY
(Chronic or recurring)

- Ear Infections
- Diabetes
- Heart disease/defect
- Convulsion/seizures
- Asthma
- Nosebleeds
- Other _____

⌘ ALLERGIES

- Hay Fever
- Plant Poisoning
- Insect stings
- Penicillin
- Animals
- Other _____

Is the child on any medications? Yes No

If yes explain and name them _____

Physical Limitations Yes No If yes describe _____

Dietary Limitations Yes No If yes describe _____

⌘ Parent/Guardian Signature _____ Date _____