

Child's Name _____

Medical Information

Child's Physician _____

Phone () _____

Address _____
Street City Zip Code

Hospital preference _____

Child's Dentist _____

Phone () _____

Does your child have allergies? _____

Does your child take regular medication? _____

Other health/physical limitations? _____

Special needs of your child: _____

People to be notified/permitted to remove child *IN CASE OF EMERGENCY* when a parent/guardian cannot be reached: Must be someone other than the custodial parent(s) or legal guardian(s).

Name _____ Address _____

City _____ Zip _____ Phone () _____

Cell Phone () _____

Name _____ Address _____

City _____ Zip _____ Phone () _____

Cell Phone () _____

I give permission to consult my child's physician/health resource listed above in case of emergency if parent cannot be reached. I have received a copy of the Child Care Facility Brochure and a copy of The Growing Place discipline policy. I verify that the information on this enrollment form is complete and accurate.

PLEASE SIGN!

Signature of Custodial Parent or Legal Guardian

Date