



# Child Registration Form

Childs Name: \_\_\_\_\_

Persons approved for child pick up:

Name: \_\_\_\_\_ Relation to Child: \_\_\_\_\_

Name: \_\_\_\_\_ Relation to Child: \_\_\_\_\_

Name: \_\_\_\_\_ Relation to Child: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone:(\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age (circle one): Birth – 18 months    18 months – 2 yrs.    3 yrs.    4-5 yrs.  
1-2<sup>nd</sup> grade    3<sup>rd</sup> grade    4-5<sup>th</sup> grade

Physician's Name and Phone number: \_\_\_\_\_

## Emergency Contacts

Person(s) On Campus to Contact in Case of Emergency:

Name \_\_\_\_\_ Relation to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

Name \_\_\_\_\_ Relation to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

Name \_\_\_\_\_ Relation to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

Person(s) Off Campus to Contact in Case of Emergency:

Name \_\_\_\_\_ Relation to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

Name \_\_\_\_\_ Relation to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

Name \_\_\_\_\_ Relation to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

## Emergency Treatment for Allergic Reactions

Allergies, Medical Conditions, Food Allergies etc.: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Medications/Dosages: \_\_\_\_\_  
(No medication will be administered to a child without written parental permission approved by Coordinator)

Name: \_\_\_\_\_ has a severe allergic

reaction to: \_\_\_\_\_

### Signs and symptoms of a severe allergic reaction can include any of the following:

Circle all that apply: hives, swelling, shortness of breath, wheezing, coughing, chest tightness, hoarseness, throat closing, vomiting, nausea, abdominal cramps, diarrhea, loss of consciousness, list any others below:

\_\_\_\_\_

Action in order to treat: \_\_\_\_\_