



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.
1-2nd grade 3rd grade 4-5th 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: _____