

Pick Up

In case of illness, accident, or emergency, the following persons may be notified and are authorized to pick up my child:

POSITIVE PHOTO IDENTIFICATION REQUIRED

1. _____ () ()
 Name Address Home Telephone Work Telephone

2. _____ () ()
 Name Address Home Telephone Work Telephone

3. _____ () ()
 Name Address Home Telephone Work Telephone

Medical

☆ _____ ()
 PHYSICIAN Address Work Telephone

_____ ()
 DENTIST PREFERENCE Work Telephone HOSPITAL PREFERENCE

Additional

List any significant facts about your child's health or behavior:

Has your child had any other examinations prior to this time (neurological, speech, hearing, ophthalmological, psychological, etc.) Yes _____ No _____
 If yes, indicate what examinations and results: _____

Does your child take any routine medications? Yes _____ No _____
 If yes, please list: _____

I heard about Family Partners... Direct Mail, TV, Billboard, Magazine Ad, Radio, Newspaper
 Personal Recommendation, Yellow Pages, Coupon, Other _____

- The parent's or legal guardian's signature below acknowledges and/or verifies receipt of the following:
- Disciplinary practices used by the child care facility
 - Authorization for Medication Policy
 - DCF Physical and Immunization forms 3040 & 680 are due within two weeks of enrollment and must be kept current throughout enrollment
 - "Know Your Child Care Center," CF/PI Publication 175-24, 06/2002
 - Participation in periodic field trips permission

All information must be filled out to process registration.

 Parent / Guardian Signature Date

 Director Signature Date

For Office Use Only

Enrollment: ____ / ____ / ____ Start ____ / ____ / ____

Assigned to Area: _____

Tuition Amount: _____

Tuition Description: _____

Registration Amount: _____ Paid: ____ / ____ / ____

Check / Receipt No.: _____

Withdrawal Date: ____ / ____ / ____ Control No.: _____