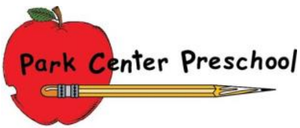

Child Information Form

Child's Name: ______________________________Primary Language:_ ________________________

Child's Address: ____ ___
Street City/Town Zip Code

Place of Birth: ____Date of Birth:_______/____/ _____

Child's Schedule ____Mon ____Tues ____Wed ____Thurs ____Fri Approx. Drop Off Time______ Approx Pick Up Time:________

Parent/Guardian Information

Name:______________________________ Name: ______________________________

Relationship:__________________________ Relationship: __________________________

Full Address:__________________________ Full Address: _______________________ _______

______________________________ ______________________________

Home E-mail Address: ______________________ Home E-mail Address: ______________________

Cell Phone: ___________________________ Cell Phone: ___________________________

Home Phone: __________________________ Home Phone: _ ________________________ _____

Parent/Guardian Business Information

Company Name: _______________________ Company Name: _______________________

Full Address:__________________________ Full Address: _______________________ _______

______________________________ ______________________________

Business Phone: _______________________ Business Phone: __________________ _______

E-mail Address: ________________________ E-mail Address: ________________________

Work Days/Hrs:________________________ Work Days/Hrs:________________________

Medical Information

Eye Color: _______ Hair Color: _________ Height: _____ Weight: _______ Race: ________ Gender ☐M ☐F

Identifying Marks: ____

Health Insurance Provider: ____

Physician Information (or Christian Science Practitioner if applicable**)**

Name of Physician/Clinic: ___________________________________ Phone: _______________________ ___

Physician Address:____
Street City/Town Zip Code

Date of Child's Last Physical : ____

Parent/Guardian Signature: ___________________________________Date:________________________

FOR CENTER USE:

Date of Admission:_____________ Age of Admission: _____________ Date Reg Fee Rec'd:________

Discharge Date:________________ Director's Initials: _____________