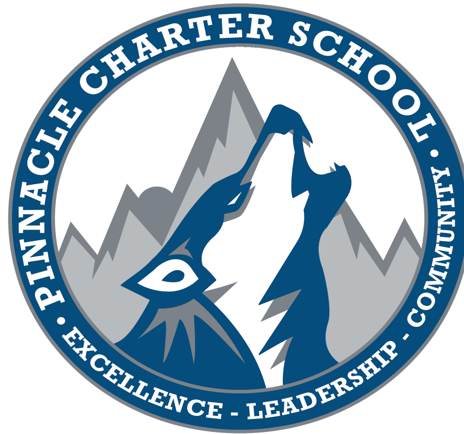

Pinnacle Cub's Den

ENROLLMENT RECORD

Date of Enrollment______________________________

Child's Name ____

Home Address ____

Home/Cell Phone ____________________**Sex M / F Age** ________**Date of Birth**____

Mother or Guardian's Name ____

Address if different from child's____

Zip__________ **Home Phone**__________**Cell Phone**___________**Email**____

Name of employment (mother/guardian) ____

Address of employment (mother/guardian) ___________________________**Work Phone**____

Father or Guardian's Name____

Address if different from child's ____

Zip__________ **Home Phone** ___________ **Cell Phone** ______________**Email** ____

Name of employment (father/guardian) ____

Address of employment (father/guardian) ____**Work Phone**__________________________

Special instructions for reaching parent or guardian

____

EMERGENCY CONTACTS

Name______________________________**Home/Cell Phone**_______________________________________

Address____

Work Phone__________________________ **Relationship to child** _____________________________

Name ______________________________**Home/Cell Phone**_______________________________________

Address____

Work Phone __________________________ **Relationship to child** _____________________________

CHILD PICK UP INFORMATION

Persons authorized to pick up your child
(Must show photo ID)

Name______________________________**Relationship to child**______________________________

Home/Cell Phone____________________**Work Phone**_______________________________________

Name______________________________ **Relationship to child**______________________________

Home/Cell Phone____________________ **Work Phone**_______________________________________

Name______________________________**Relationship to child**______________________________

Home/Cell Phone____________________**Work Phone**_______________________________________

Name______________________________**Relationship to child**______________________________

Home/Cell Phone____________________**Work Phone**_______________________________________

Name, address and phone number of child's doctor ____

____

Name, address and phone of child's dentist ____

____

Hospital of Preference_________________________**Address**____________________**Phone**_____________________

Chronic Medical conditions ____

____

Does your child have a health care plan? ____
If yes, the health care plan must be provided on or before the first day the child is in care.

Is your child fully immunized? ____
If yes, the health care plan must be provided on or before the first day the child is in care.

Food Allergies ____

____

HEALTH HISTORY

(Chronic or recurring)
Ear Infections ___________________________
Diabetes__________________________________
Heart disease/defect______________________
Convulsion/seizures______________________
Asthma _________________________________
Nosebleeds_______________________________
Measles__________________________________
Mumps___________________________________
Chicken Pox ______________________________

ALLERGIES

(Nature of Reaction)
Hay Fever___________________________________
Plant Poisoning______________________________
Insect stings__________________________________
Penicillin____________________________________
Other drugs__________________________________
Animals_____________________________________
Food____
Other____

Flu shot Yes ________________No_________________If Yes When?_____________________________________

Operations or serious injuries (dates) ____

____

Is the child on any medications? ____

If yes, please describe____

____

Physical limitations ____

Describe if yes____

Dietary limitations____

Describe if yes____

Vision____

Hearing____

Are there any activities that you prefer that your child NOT participate in? __________________________________

If so please list: ____

____

____

Authorization for Emergency Medical Care

I hereby give my permission to CUB'S DEN to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide emergency medical or surgical care for my child,____

It is understood that the child care provider will make a conscientious effort to locate the parent/guardians and emergency contacts listed on the registration document before any action will be taken. If it is not possible to locate emergency contacts listed treatment will not be delayed. I/we will accept the expense of emergency transportation, medical or surgical treatment.

Parent/Guardian Signature______________________________________Date_______________