

Child Enrollment Information

Please fill out EVERY LINE below. This includes full address, phone numbers, and medical history. This is a Washington State Licensing Requirement (Wac #0510). We apologize for any inconvenience this may cause, however we will NOT accept your child for care until ALL forms are completed in FULL.

Child's Name: _____

Birth Date: _____

Home Address: _____

Parent Name: _____

Social Security #: _____

Parent Address (if different than child's):

Home Phone #: _____

Work Phone #: _____

Email address: _____

Cell Phone #: _____

Parent Name: _____

Social Security #: _____

Parent Address (if different than child's):

Home Phone #: _____

Work Phone #: _____

Email address: _____

Cell Phone #: _____

Emergency contacts

These are the people other than yourself with permission to pick up your child in case of emergency. Contacts will be notified in the order they are listed.

#1 Contact Name: _____

Home Phone #: _____

Address: _____

Work Phone #: _____

Cell Phone #: _____

#2 Contact Name: _____

Home Phone #: _____

Address: _____

Work Phone #: _____

Cell Phone #: _____

Out of state emergency contact:

Contact Name: _____

Home Phone #: _____

Address: _____

Work Phone #: _____

Cell Phone #: _____

Who does NOT have permission to pick up your child?

(if there is a restraining order, we must have a copy on file)

Medical / Health Care Information

Please fill out ALL information below including ALL addresses and phone numbers. If you don't have a doctor or dentist for your child, please write N/A on the line provided for the Doctor or Dentist name.

Child's Doctor Name: _____

Doctor Office: _____

Address: _____ Office Phone #: _____
 _____ Alt. Phone #: _____
 _____ Date of last visit: _____

If unavailable, another licensed doctor may treat my child: Yes / No

#1 Insurance Company Name: _____ Contract and Group Number: _____

Policy holder: _____ Employers Name: _____

Child's Dentist Name: _____

Dental Office: _____

Address: _____ Office Phone #: _____
 _____ Alt. Phone #: _____
 _____ Date of last visit: _____

If unavailable, another licensed dentist may treat my child: Yes / No

#2 Insurance Company Name: _____ Contract and Group Number: _____

Policy holder: _____ Employers Name: _____

Immunizations current?	Yes	No	
Any special health problems?	Yes	No	
Any allergies to food or medication? (a doctors note may be required)	Yes	No	
Regular medications taken?	Yes	No	
Does your child receive any type of therapy or special services?	Yes	No	
Are there any community resources I can assist you in locating?	Yes	No	
Any other pertinent information we need to know about?	Yes	No	

