



## CRYSTAL DAY CARE

### MEDICAL /REGISTRATION INFORMATION REQUIRED FOR CHILDCARE ENROLLMENT

This form needs to be signed by a physician and returned with a **copy of your child's immunizations** by or on the day your child starts.

Child's Full Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address:

\_\_\_\_\_

Phone: \_\_\_\_\_

Parents: Married\_\_\_ Single\_\_\_ Separated\_\_\_ Divorced\_\_\_ Widow(er)\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Mother's Address: \_\_\_\_\_ Father's Address:

\_\_\_\_\_

Mother's Phone numbers:

Father's Phone numbers:

W \_\_\_\_\_

W \_\_\_\_\_

H \_\_\_\_\_

H \_\_\_\_\_

C \_\_\_\_\_

C \_\_\_\_\_

Mother's fax: \_\_\_\_\_

Father's fax: \_\_\_\_\_

E-mail address: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Mother's occupation: \_\_\_\_\_ Father's occupation: \_\_\_\_\_

Mother's employer: \_\_\_\_\_ Father's employer: \_\_\_\_\_

People other than a parent to be notified in an emergency if a parent is not available.

Name/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

People other than parent who are authorized to pick up this child.

Name/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Please name and describe people who are allowed to pick up your child.

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I give permission for staff to assist my child, in an emergency situation, in any way needed.

Yes\_\_\_ No\_\_\_

I give permission for staff to put on their sunscreen if the weather warrants it.

Yes\_\_\_ No\_\_\_

I give permission for staff to use diaper creams and ointments if my child needs it. Yes\_\_\_ No\_\_\_

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please complete the brief medical history below.

Past Illnesses – check those the child has had and give approximate dates:

Chicken Pox \_\_\_\_\_

Rubeola \_\_\_\_\_

Rubella \_\_\_\_\_

Rheumatic Fever \_\_\_\_\_

Asthma \_\_\_\_\_

Hay fever \_\_\_\_\_

Diabetes \_\_\_\_\_

Mumps \_\_\_\_\_

Epilepsy \_\_\_\_\_

Whooping Cough \_\_\_\_\_

Poliomyelitis \_\_\_\_\_

Other \_\_\_\_\_

Comments:

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Allergies:

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Surgery/Accidents/Serious Illness/Chronic Medical Condition:

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Describe any physical condition requiring the facility's special attention:

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Current Medication:

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Condition Medication is for:

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Date of most recent examination of the child:

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Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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Physician's Address:

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\_\_\_\_\_  
(Signature of licensed physician or nurse practitioner) Date: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_