GAARDE CHRISTIAN DAY CARE
REGISTRATION FORM

Student's Last Name (*Legal*): ___________________________ First Name:________________________ MI:_________

Nick Name or name child prefers if different from above____

Age___________ Birth date_____________________________ Male______ Female________

Child lives with: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Other _____________

Mother's Name:___________________________ Father's Name:__________________________________

Mother's SSN: ____________________________ Father's SSN: ___________________________________

Mother's Address:__________________________ Father's Address:________________________________

____ ____

____ ____

Mother's Home #:_________________________ Father's Home #:________________________________

Mother's Work #:__________________________ Father's Work #:________________________________

Mother's Employer:________________________ Father's Employer:______________________________

E-mail:__________________________________ E-mail:____

Cell #:__________________________________ Cell #:____

EMERGENCY CONTACTS

Other persons authorized to pick up the child listed above and permitted to remove the child in case of emergency or injury, if parents cannot be reached.

(List in order of preferred contact)

Name Phone Relationship

1.____

2.____

3.____

4.____

5.____

6.____

NOTE: Parent/guardian must given written notification in the event someone other than persons listed above will pick up the child from day care.

OUT-OF-STATE EMERGENCY CONTACT

Name Phone Relationship

1.____

2.____

MEDICAL INFORMATION

PHYSICIAN: ______________________________ **PHONE**: ________________________

PHYSICIAN ADDRESS: ____

DENTIST:______________________________ **PHONE:**________________________

INSURANCE COMPANY: ______________________ **PHONE**: ________________________

POLICY #/GROUP #: _________________________ **SUBSCRIBER**: ____________________

ALLERGIES: ❒Food __________________________ ❒Medicines ________________________

❒Environmental ____________________ ❒ Other: ___________________________

(If no allergies, please leave box(es) blank)

DOES YOUR CHILD HAVE A REACTION TO BEE STINGS? ❒Yes ❒No ❒Unknown

CURRENT MEDICATIONS: ____

SERIOUS ILLNESSES/ACCIDENTS TO-DATE: _______________________________________

DATE OF LAST TETANUS IMMUNIZATION: ____

MEDICAL TREATMENT, TRANSPROTATION AND HOSPITAL AND/OR PHYSICIAN'S CARE

In case of an accident or serious illness, I request Gaarde Christian Day Care to contact me. If the Day Care is unable to reach me, I hereby authorize Gaarde Christian Day Care permission to seek medical treatment for my child in the event such treatment is deemed necessary and for my child to be transported by an emergency vehicle to a medical facility for treatment. I consent to all medical and surgical treatment by the attending physician. I agree to accept responsibility for any financial indebtedness incurred due to the injury/illness.

Parent/Guardian, by signing below, you are acknowledging that you have read, understand, agree to and completed the necessary information required for the Registration, Medical Release, and People Authorized to Pick-up Child, and that the information is current.

Signature of parent/guardian____ Date____________________