FAMILY CHILD CARE LEARNING HOME
CHILDREN'S ENROLLMENT RECORD

CHILD'S INFORMATION

Child's Full Name:		**Child Resides with:**
Nickname:		
Date of Birth:		**Child's Age:**
Child's Home Address: (Include Number and Street Name)		
City/State/Zip:		

OTHERS AUTHORIZED TO PICK UP CHILD FROM FAMILY CHILD CARE LEARNING HOME

For your child's safety, I only allow children to leave my home with you (the person enrolling the child) and the person(s) you have specified below (One person should be listed that is not a parent/guardian). Changes to this list must be made in writing.

Name:		**Name:**	
Address:		**Address:**	
City/State/Zip:		**City/State/Zip:**	
Telephone:		**Telephone:**	
Relationship to child & guardian:		**Relationship to child & guardian:**	

PARENT(S)/GUARDIAN(S) INFORMATION

	Mother	**Father**
Name:		
Home Address:		
City/State/Zip:		
Home Telephone:		
Cell Telephone:		
Pager Number:		

PARENT(S)/GUARDIAN(S) WORK INFORMATION

Mother's Employer:	
Work Telephone:	
Work Address:	
City/State/Zip:	
Father's Employer:	
Work Telephone:	
Work Address:	
City/State/Zip:	

SPECIAL INSTRUCTIONS TO CONTACT PARENTS:

OTHER EMERGENCY CONTACT INFORMATION

In case of illness or other emergency, give the name, address and telephone number of nearest relative or friend who can be contacted if the parents cannot be reached.

Name:	
Relationship to Child:	**Grandparent Aunt/Uncle Sister/Brother Friend**
Address: (Include Number and Street Name)	
City/State/Zip:	
Telephone:	
CHILD'S PEDIATRICION OR PRIMARY SOURCE OF HEALTH CARE	
Name of Physician:	
Telephone:	
Address: (Include Number and Street Name)	
City/State/Zip:	

MEDICAL EMERGENCY STATEMENT

I hereby give _____ (Name of Family Child Care Provider) permission to take my child, _____, to a hospital for medical treatment when I cannot be reached.

_____ _____

Parent Signature **Date Signed**

Note: Many emergency services personnel often require notarized authorization in order to proceed with care. Please request from your provider and complete a **MEDICAL CARE AND EMERGENCY CONTACT INFORMATION** form in order to provide this detailed information.

PERMISSION TO TAKE THE CHILD OFF THE PREMISES

I hereby give _____ (Name of Family Child Care Provider) permission to take my child, _____, on excursions from the family day care home that might include the following types of activities:

(The provider should fill in the above list with activities that she might provide away from home. Examples might include trips to the store, riding in the car, swimming, etc.)

Parent/Guardian **Date**

CHILD'S SCHEDULE AND INTERESTS

The following information will assist the provider to understand and care for your child.

Please describe your child's eating habits, i.e. food likes and dislikes, etc.
NOTE: Complete **INFANT FEEDING PLAN** (next page) for children who are under 1 year of age.

Describe the play activities that your child likes, both indoors and out-of-doors.

Describe your child's naptime habits.

Describe your child's toilet and hygiene habits.

Please add any other special information that is important to your child's care here:

Does your child have any known allergies? Yes No If yes, please explain:

Does your child have any known medical problems? Yes No If yes, please explain:

Please read the statement below and initial the box to the left if you have provided this information.

☐ My child has known allergies and/or other medical problems. I have requested from my provider and completed a **MEDICAL CARE AND EMERGENCY CONTACT INFORMATION** form in order to provide this detailed information.

Parent/Guardian _____ **Date**

Medical Care and Emergency Contact Information

Child's Name: _____ Birth Date _____

Address _____

Mother's Name _____ Phone (H) _____ Phone (W) _____

Father's Name _____ Phone (H) _____ Phone (W) _____

Alternate Emergency Contact 1) _____ Phone _____

Alternate Emergency Contact 2) _____ Phone _____

Child's Physician _____ Phone _____

Family Physician _____ Phone _____

Known Allergies of Child (medicine, food, etc.) _____

Describe past serious illnesses or hospitalization with dates _____

Medicines taken by child _____

Date of last tetanus injection _____

Describe all physical conditions or illnesses, which could affect the child's participation in the programs or proper medical treatment (diabetes, epilepsy, poor blood clotting, etc.) _____

Health Insurance: Company _____ Policy Number _____

Notarized Emergency Medical Treatment Consent

I hereby give Latrenia Ramnath / Charlotte Willis permission to provide first aid care for my child, _____. In the event I cannot be reached, I hereby authorize Latrenia R or Charlotte W. to transport my child to the emergency room of the hospital(s) listed below. And I hereby grant my consent for the hospital and its medical staff to provide my child with emergency medical treatment which a physician deems necessary (including anesthesia). If I have not specified any hospital(s) below, my child may be taken to and cared for at the nearest hospital. I agree to accept financial responsibility for all medical expenses incurred.

Hospital _____ Hospital _____

_____ Nearest Hospital

_____ _____

Parent/Guardian Date Parent/Guardian Date

State of: _____

County of: _____

The foregoing Consent was acknowledged before me this _____ day of _____, 20 _____, by _____ and _____.

(Notary Seal) Notary Public My Commission Expires:

PARENT/GUARDIAN NOTICE OF NO LIABILITY INSURANCE AND ACKNOWLEDGMENT

(Only Complete this Form if Instructed by your Child Care Provider)

I understand I am being informed in writing by signing this acknowledgment that this child care facility does not carry liability insurance sufficient to protect my children in the event of an injury, etc.

Parents'/Guardians' Signature(s):

_____ Date: _____

_____ Date: _____

Printed Name(s):

_____

_____

Per SB 24 (2004) requiring child care facility owners who are not covered by liability insurance to **provide and retain written notice** regarding no coverage to the parents and guardians.

* Due to covid,

Love and Learning Daycare

Child Enrollment Form for the Child and Adult Care Food Program

Family Day Care Home Name Latrenia Ramnath

CHILD(REN)'S INFORMATION:

Child's Name (1) _____ Date of Birth ____/____/____ (Month / Day / Year)

Child's Name (2) _____ Date of Birth ____/____/____ (Month / Day / Year)

Home Address _____ *Home Phone* _____

Normal Days of Care with the Provider: ___S ___M ___T ___W ___TH ___F ___S Check if Parent works multiple shifts

Normal Hours of Care with the Provider: _____ AM _____ PM

Meal Participation with the Provider ___Breakfast ___Snack (AM) ___Lunch ___Snack (PM) ___Supper

SCHOOL INFORMATION:

School/Child Care Center (1) _____ Grade (1) _____

School/Child Care Center (2) _____ Grade (2) _____

My child(ren) participate(s) in the following meals at school, Head Start center, or child care center:
[ ] Breakfast [ ] AM Snack [ ] Lunch [ ] PM Snack [ ] Supper

PARENTAL INFORMATION:

Mother's Name _____ Work Hours _____

Work Name & Address _____ Work Phone _____ Home Phone _____

Father's Name _____ Work Hours _____

Work Name & Address _____ Work Phone _____ Home Phone _____

Are there any unusual guardianship or custodial relationships? _____

Persons authorized to pick up child(ren) _____

Special Needs of Child (1) _____

Medical Information (allergy, sickness, etc.)(1) _____

Special Needs of Child (2) _____

Medical Information (allergy, sickness, etc.)(2) _____

In case of injury of accident _____ *Physician's Name* _____ *Physician's Phone* _____ *Hospital of Choice*

I hereby give permission to treat my child(ren) in case of medical emergency.

_____ *Parent's Signature* _____ *Parent's Signature* _____ *Date*

NAMES OF TWO OTHER PERSONS THAT CAN BE CONTACTED IN CASE OF EMERGENCY

Name _____	Name _____
Address _____	Address _____
Phone _____	Phone _____

My child (1) is: [ ] Related to Provider: Relationship _____ [ ] Paying for Care
[ ] Not Related to Provider [ ] Not Paying for Care [ ] Notarized Statement on file

My child (2) is: [ ] Related to Provider: Relationship _____ [ ] Paying for Care
[ ] Not Related to Provider [ ] Not Paying for Care [ ] Notarized Statement on file

I understand that my provider has applied to receive federal funds for meals served to my child(ren) and that I may be contacted to verify my child(ren)'s attendance. I have attached current immunization record(s) for my child(ren).

Child's Age (1) _____ _____ Enrollment Date (1) _____ Withdrawal Date (1) _____
Reason for Withdrawal _____

Child's Age (2) _____ _____ Enrollment Date (2) _____ Withdrawal Date (2) _____
Reason for Withdrawal _____

Wic information received _____ *Parent's Signature*

NOTE: Providers MUST retain emergency contact information for every child. Sponsors should retain a copy of this form to validate enrollment.

Revised 2/2005
CACFP
FSFA