Child Information Form

Child's Name: ______________________________ Primary Language: _________________________
Child's Address: ____
Street City Town Zip Code
Place of Birth: ____Date of Birth: _____/_____/_____
Child's Schedule: MON ___________ TUE ___________ WED ___________ THU ___________ FRI ____________

Parent/Guardian Information

Name: ____
Relationship: ___________________________________
Address: ______________________________________
____
____
Home E-mail Address: ___________________________
____
Cell Phone: ____________________________________
____
Home Phone: ___________________________________
____

Name: ____
Relationship: _____________________________________
Address: ____
Home E-mail Address:
Cell Phone:
Home Phone:

Name: ____
Relationship: ___________________________________
Address: ______________________________________
____
____
Home E-mail Address: ___________________________
____
Cell Phone: ____________________________________
____
Home Phone: ___________________________________
____

Name: ____
Relationship: _____________________________________
Address: ____
Home E-mail Address:
Cell Phone:
Home Phone:

Others in Family Relationship:
____

Parent/Guardian Business Information

Company Name: _____________________________
____
Address: ___________________________________
____
____
____

Company Name:
Address:

Business Phone: ___________________________ Business Phone: ___________________________

E-mail Address: ____________________________ E-mail Address: ____________________________

Medical Information

Eye Color: ______ Hair Color: _______ Height: ______ Weight: ______ Race: ______ Gender □M □F

Identified Allergies: ____

Identifying Marks: ____

Health Insurance Provider: ____

Physician/Dentist Information

Name of Physician/Clinic: _______________________________________ Phone: _________________________

Physician Address: ____

Street City/Town Zip Code

Name of Dentist: ____ Phone: _________________________

Dentist Address: ____

Street City/Town Zip Code

Parent/Guardian Signature: ______________________________________Date: __________________________

FOR CENTER USE: Center: ______________________________ Date of Admission: _________________________________

Age of Admission: ______________________________ Date Registration Fee Rec'd: ________________________

Discharge Date: _______________________________ Director's Initials: ________________________________