Updated 1/2025

Enrollment Form 2025

Child's Name: _____ Date of Enrollment: _____

Home Address: _____

Home Phone: _____ Sex: M F Age: _____ Date of Birth: _____

Family Members: _____

Mother or Guardian's Name: _____

Address if different from child's: _____

Zip: _____ Home Phone: _____ Cell Phone: _____ Email: _____

Name of Employment (Mother/Guardian): _____

Address of Employment: _____ Work Phone: _____

Father or Guardian's Name: _____

Address if different from child's: _____

Zip: _____ Home Phone: _____ Cell Phone: _____ Email: _____

Name of Employment (Father/Guardian): _____

Address of Employment: _____ Work Phone: _____

Special instructions for reaching parent or guardian: _____

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Emergency Contacts:

1. Name: _____Home Phone: _____Address: _____

Work Phone: _____ Relationship to child: _____

2. Name: _____Home Phone: _____Address: _____

Work Phone: _____ Relationship to child: _____

Child Pickup Information

Persons Authorized to pick up your child (Must show photo ID)

Name: _____

Home Phone: _____ Work Phone: _____

Name: _____

Home Phone: _____ Work Phone: _____

Name: _____

Home Phone: _____ Work Phone: _____

Name, address and phone number of child's doctor:

_____

_____

Name, address and phone number of child's dentist:

_____

_____

Hospital of Preference (Please check one): ☐ UC Health Memorial Hospital
4050 Briargate Pkwy
Colorado Springs, CO 80920
719-364-5000

☐ St. Francis Medical Center
6001 E Woodmen Rd.
Colorado Springs, CO 80923

☐ Other _____

_____

_____

Chronic Medical Conditions: _____

Does your child have a health care plan? _____

If yes, the health care plan must be provided on or before the first day the child is in care.

Is your child fully immunized? _____

Complete immunization records must be provided on or before the first day the child is in care.

Food Allergies: _____

Health History

(Chronic or Recurring)

Ear Infections: _____

Diabetes: _____

Heart disease/defect: _____

Convulsions/seizures: _____

Asthma: _____

Nosebleeds: _____

Measles: _____

Mumps: _____

Chicken Pox: _____

Flu or Flu Shot: _____

Allergies

(Nature of Reaction)

Hay Fever: _____

Plant Poisoning: _____

Insect Stings: _____

Penicillin: _____

Other drugs: _____

Animals: _____

Food: _____

Other: _____

Operations or serious injuries (dates): _____

Is the child on any medications? (Explain): _____

If yes, please describe: _____

Physical Limitations: _____ Describe if yes: _____

Dietary Limitations: _____ Describe if yes: _____

Vision: _____ Hearing: _____

Are there any activities that you prefer that your child **NOT** participate in?

If so, please list: _____

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I hereby give permission for _____ to call a doctor or emergency medical services and for the doctor, hospital or medical service to provide emergency medical or surgical care for my child, _____.It is understood that the child care provider will make a conscientious effort to locate the parent/guardians and emergencycontacts listed on the registration document before any action will be taken. If it is not possible to locate emergency contacts listed treatment will not be delayed. I/we will accept the expense of any emergency transportation, medical or surgical treatment.

Parent/Guardian Signatures:

_____ Date: _____

_____ Date: _____

Annual Updates

Parent/Guardian Signatures:

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____