

Colorado Child Care Registration Form

Date of Enrollment: _____

Child's Name: _____ Nickname: _____

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: _____

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): The Children's Hospital
13123 East 16th Ave
Aurora, CO 80045
720-777-1234

Denver Health Emergency Department
777 Bannock St Pavilion A,
Denver, CO 80204
303-436-6000

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.

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: _____

I hereby give permission to _____ 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 childcare provider will make a conscientious effort to locate the parent/guardians and emergency contacts 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: _____