Creative Wonders Child Care Registration Form

CHILD'S INFORMATION

Child's Full Name: _____ Birth Date: _____/_____/_____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____

Nickname: _____ IGH ONLY - Door Code :_____

PARENT/GUARDIAN INFORMATION

Mother's Full Name: _____ Cell/Home Phone: _____

Address: _____ Cell Provider: _____

City: _____ State: _____PC/Zip Code: _____

Occupation: _____ Work Phone: _____ext._____

Name of Employer_____ Address: _____

City: _____ Work Hours: _____

Email address:_____

Father's Full Name: _____ Cell/Home Phone: _____

Address: _____ Cell Provider: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Work Phone: _____ext._____

Name of Employer_____ Address: _____

City: _____ Work Hours: _____

Email address:_____

CHILD PICK-UP INFORMATION

Please list below Alternative person (s) who have ***Permission*** to pick up your child.

***Note: Anyone picking up your child must have picture ID.**

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

EMERGENCY CONTACTS

Primary Emergency Contact (other than parents or guardian)

Name: _____ Address: _____

Cell/Home Phone: _____ Work Phone: _____

Relationship to Child: _____

Secondary Emergency Contact (other than parents or guardian)

Name: _____ Address: _____

Cell/Home Phone: _____ Work Phone: _____

Relationship to Child: _____

Any Special Instructions on how to reach parents:

_____

_____

EMERGENCY INFORMATION: Completing this section give us written authorization to act in an emergency

Child's Physician: _____

Address: _____ Phone: _____

Child's Dentist (if child has not gone, put parent's dentist): _____

Address: _____ Phone: _____

Insurance Company: _____ Policy #: _____

Default Hospital: Children's Hospital St. Paul 651-220-6000 or Write in Preferred Hospital:

_____

Any Dietary or Medical Needs of the child: No known allergies at this time: _____ (initial and date)

Regular Medications: _____

Medicine allergic to: _____

Food Allergies determined by doctor: _____

Parent Preference: _____

Intolerance to: _____

Any other Allergies: _____

Any other health conditions/needs:

_____