

Creative Wonders Child Care Registration Form

CHILD'S INFORMATION

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

Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____

Nickname: _____

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: _____ City/State: _____

Cell/Home Phone: _____ Work Phone: _____

Relationship to Child: _____

Secondary Emergency Contact (other than parents or guardian)

Name: _____ Address: _____ City/State: _____

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: _____ Phone: _____

Address: _____ Fax: _____

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

Address: _____ Phone: _____

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:
