Grace Children's Center
A Ministry of Grace Lutheran Church

Childcare Registration and Emergency Contact Form

Procare:	Start Date:	End Date:	Classroom:	Center

Child Full Name	Nickname	Date of Birth	Resides With

Child's Street Address (City/State/Zip):

Child's parent/guardian name:	Cell Phone #:	Cell Phone Provider:

Residence Street Address (City/State/Zip):

Email Address:

Where can you be reached while your child is in care: Employer/Address:	Work Phone #:

Responsible for:	Drop Off	Pick Up	Both

Child's parent/guardian name:	Cell Phone #:	Cell Phone Provider:

Residence Street Address (City/State/Zip):

Email Address:

Where can you be reached while your child is in care: Employer/Address:	Work Phone #:

Responsible For:	Drop Off	Pick Up	Both

Other than you, who lives with your child?

Authorized for Emergencies		Name	Relationship	Phone Number
Yes	No			
Yes	No			

Who does not have permission to pick up your child? (A copy of supporting court document must be on file)

Name	Reason	Description or Identification

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Child's Health History

Physician Information:		Dentist Information:	
Name:	Phone #:	If your child does not have a dentist, please indicate the person we should contact in the event of a dental emergency:	
Address:		Name:	Phone #:
		Address:	
Date of Last Exam:		Date of Last Exam:	

Health History		Yes	No
Does your child have any health problems? (If yes, please explain)			
Does your child have regular medications? (If yes, please explain			
Other health issues			

For all medications, you will need to complete a medication authorization form. For allergies or asthma, you must complete an allergy and/or asthma plan, and have it signed by your pediatrician.

Child's medical insurance coverage:

Insurance company name:	Member/policy number:
Policy holder name:	Employer name:

Consent to medical care and treatment of minor children

Child's Name		I give permission that my child may be given first aid/emergency treatment by the child care licensee and/or qualified staff at: Grace Children's Center and Grace Children's Center 2

When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health. I waive my right of informed consent to such treatment.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment. I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.

Parent's Signature	Date: