



Dear Family,

We are excited to welcome you and your family to Early Years Discovery Center! Below are the necessary forms to fill out.

- **Registration Form** – This form includes information about your child and parent information. Also on that form is a section “Authorized to Release Child” this is where you list anyone who is allowed to pick up your child (ex. Grandparents, Aunts and Uncles, etc.). The people listed in this section will have unlimited access to your child during the center hours.
- **Medical & Emergency Information** – This form is what we will use in the case of illness or emergency. If your child develops a fever of 100 degrees or higher, we would need to contact you. Please list the phone numbers, in the order you would like us to call them.
- **Immunization Form** – please have the clinic that your child regularly attends print a copy of your child’s latest immunization records. These immunizations must all be appropriate for the child’s age, as prescribed by the ND state department of health.
- **Parent Statement on Health of Child**– This sheet needs to be filled out prior to your start date to ensure the health of all our children!
- **Child Information Card** – This form is put in our emergency binder and given to your child’s classroom to contact you in case of an emergency. This form should repeat a lot of the same information as the medical and emergency form.

These forms along with a \$50 enrollment fee are due at the time of enrollment per child.

Thank you for your interest in Early Years!
We look forward to getting to know you and your child!



Registration Form

Please fill out completely and legibly.

For Office Use Only:
 Date of Enrollment: _____
 Start Date: _____
 Date of Termination: _____

CHILD'S INFORMATION

Child's Name _____
(First Name) (Middle Name) (Last Name)
 Date of Birth _____ - _____ - _____ Age _____ Sex M F
 Typical Weekly Schedule: Arrival Time _____ Departure Time _____ Will vary _____
 Meals to attend (circle all that apply) Breakfast (7:45-8:15) Lunch (11:00-11:30) Snack (2:00-2:30)

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name _____
(First Name) (M.I.) (Last Name)
 Relationship to Child _____
 Address _____
 City _____ State _____ Zip Code _____
 Email Address: _____
 Home Phone #() - Cell Phone #() -
 Employer _____ Work Phone #() - Ext. _____
 Address _____ City _____ Work Hours _____

Parent/Guardian Name _____
(First Name) (M.I.) (Last Name)
 Relationship to Child _____
 Address _____
 City _____ State _____ Zip Code _____
 Email Address: _____
 Home Phone #() - Cell Phone #() -
 Employer _____ Work Phone # _____ Ext. _____
 Address _____ City _____ Work Hours _____

Parents Marital Status (circle one) Married Divorced Single
 Child's Primary Residence (circle all that apply) Both Mother Father
 If divorced, who has legal custody? (circle all that apply) Joint Mother Father

AUTHORIZED TO RELEASE CHILD

Unless otherwise authorized by you in writing, no one but you or your spouse, may pick up your child from Early Years. Please list any others you would like to authorize for this purpose.

Name _____ City _____ Phone _____

Relationship to the child: _____

Name _____ City _____ Phone _____

Relationship to the child: _____

Name _____ City _____ Phone _____

Relationship to the child: _____

Name _____ City _____ Phone _____

Relationship to the child: _____

Name _____ City _____ Phone _____

Relationship to the child: _____

Name _____ City _____ Phone _____

Relationship to the child: _____

REFERRAL INFORMATION

Were you referred to Early Years? Yes No If Yes, by whom? _____

BILLING INFORMATION

Parent/Guardian Name(s): _____

Social Security Number of Parent(s): _____ - _____ - _____

Are you on Childcare Assistance? Yes No If yes, fill out below.

Case Manager's Name _____ Phone _____

PARENT SIGNATURES

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Medical & Emergency Information

Please fill out completely and legibly.

CHILD'S INFORMATION

Child's Name _____
(First Name) (Middle Name) (Last Name)
Date of Birth _____ - _____ - _____ Age _____ Sex M F
Address _____
City _____ State _____ Zip Code _____

PARENT/GUARDIAN EMERGENCY INFORMATION

In the case of illness or an emergency, what is our best means of contacting you?

Parent/Guardian _____ Employer _____

1st Call: (circle one) Work Cell Other _____ Phone #() - _____

2nd Call: (circle one) Work Cell Other _____ Phone #() - _____

Parent/Guardian _____ Employer _____

1st Call: (circle one) Work Cell Other _____ Phone #() - _____

2nd Call: (circle one) Work Cell Other _____ Phone #() - _____

EMERGENCY CONTACT INFORMATION

Please list at least two people other than Parent/Guardian(s) that we would be able to contact if we are unable to get a hold of the Parent/Guardian(s) in case of illness or an emergency.

Name _____
(First Name) (M.I.) (Last Name)

Relationship to Child _____ City _____ State _____

Home Phone #() - _____ Cell Phone #() - _____

Name _____
(First Name) (M.I.) (Last Name)

Relationship to Child _____ City _____ State _____

Home Phone #() - _____ Cell Phone #() - _____

Name _____
(First Name) (M.I.) (Last Name)

Relationship to Child _____ City _____ State _____

Home Phone #() - _____ Cell Phone #() - _____

MEDICAL INFORMATION

Child's Doctor _____

Clinic/Hospital _____

Clinic Phone # () - _____ OR Direct Phone # () - _____

If your child has allergies to anything please list them here.

Allergies _____

If your child has a Medical Condition, we need to be aware of that. Please list here.

Medical Conditions _____

If your child takes any medications daily, please list them here.

Medications _____

DENTAL INFORMATION

Child's/Family's Dentist _____

Office Location _____ Office Phone # () - _____

EMERGENCY CONSENT

It is the policy of *Early Years Enrichment Center* to notify a parent when a child is ill or needs medical attention. Occasionally, we cannot contact a parent and we need to get immediate help for the child. Our procedure is to take the child to the nearest emergency service.

Please sign below so that we can take appropriate action on behalf of your child.

I HEREBY GIVE MY/OUR CONSENT FOR MY/OUR CHILD _____
WHEN ILL/ INJURED, TO BE TAKEN TO THE NEAREST EMERGENCY CENTER BY THE STAFF OF EARLY YEARS ENRICHMENT CENTER WHEN I/WE CANNOT BE CONTACTED. I CONSENT TO AN AMBULANCE BEING CALLED TO TRANSPORT THE CHILD, IF NECESSARY. I FURTHER AGREE TO PAY ALL COSTS INCURRED FOR TRANSPORT.

PARENT SIGNATURES

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____



PERMISSION AGREEMENT

I hereby grant permission for my child to use all of the play equipment and participate in all of the activities at Early Years.

I hereby grant permission for my child to leave the center premises under supervision of a staff member for neighborhood walks or for field trips in an authorized vehicle.

I hereby grant permission for the Director or acting Director to take whatever steps may be necessary to obtain emergency medical care if warranted. These steps may include, but are limited to:

- 1) Administer the necessary first aid and or CPR
- 2) Call 911 and following their recommendations, which may include having a child transported to an emergency hospital.
- 3) Attempt to contact the parent or guardian
- 4) Attempt to contact the child's physician or another physician if the child's doctor is not available.
- 5) Attempt to contact the parent through any of the persons listed on the "Child Information Card" completed for the center.

I understand that any expenses incurred will be the responsibility of the child's family.

I understand that Early Years will not be responsible for anything that may happen as a result of false information given at the time of enrollment.

I have been informed that Early Years will not assume responsibility for a child who has not been signed in, nor is Early Years responsible for the supervision of children after they are signed out. For kindergarten and school age children, Early Years will assume the responsibility of your child without being signed in once Early Years has picked up your child from school.

Child's Name _____

Signed _____ Date _____
(Father or legal guardian)

Signed _____ Date _____
(Mother or legal guardian)

Consent to Review Records

I, _____, give permission for my child's records to be reviewed by the center's administrators, authorized Department of Human Services representatives, and the required health consultant.

Signature of Parent _____

Date _____

Typical Weekly Schedule

Please let us know if your child's schedule will change at all throughout the week. We use this form to ensure we are properly staffed at all times. If your arrival times differ from those listed, please speak with the Director! Thanks!

MONDAY: _____

TUESDAY: _____

WEDNESDAY: _____

THURSDAY: _____

FRIDAY: _____

CHILD'S NAME: _____

PARENT'S SIGNATURE: _____

Sunscreen and Photography Permission Slip

I give Early Years permission to apply sunscreen to my child _____

I give Early Years permission to photograph my child for center purposes only!

Child's name _____

Age _____

Signature of Parent _____

Date _____



PARENT'S STATEMENT ON HEALTH OF CHILD
 ND DEPARTMENT OF HUMAN SERVICES/CFS
 SFN 847 (6-2006)

Clear Fields

INSTRUCTIONS: This form must be completed annually for any child enrolled in a licensed early childhood facility.
 This form is completed by a parent or guardian of the child.

Name of Child:	Birth date:	Enrollment date:	Please check one: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Dropin <input type="checkbox"/> B/A School
Parents or Guardians:		Relationship:	
Address:	Home Telephone Number:	Work Telephone Number:	
Family Physician:	Clinic:	Telephone Number:	
Hospital:		Telephone Number:	
Last Visit To Doctor:	Child's Height:	Child's Weight:	
Does The Child Have Any food, medication or environmental allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, List Allergies:	Describe Allergy Reaction:	Usual Treatment:	
Please Check If Any Of The Following Conditions Exist:			
<input type="checkbox"/> Asthma	<input type="checkbox"/> Vision Impairment	<input type="checkbox"/> Medication Allergy	<input type="checkbox"/> Cancer
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Other _____
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Seizures Disorder	<input type="checkbox"/> Frequent Earaches	
Please Explain All Checked Items:			
Is The Child Under Current Medical Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list:			
Are There Any Medications That The Child Takes Daily? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list:			
Describe Any Limitation Your Child May Have For Participation In An Early Childhood Program:			
Has Your Child Received Any Immunizations Within the Past Year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide proper documentation.			

INSURANCE:
 Liability insurance is not a requirement for a license to provide family or group child care. Please review with your child care provider the liability coverage that is presently in place.

CERTIFICATION:
 I certify that the above information is true to the best of my knowledge.

Parent or Guardian's Signature:	Date:
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Child Information Card

Child's Name _____ Date of Birth: _____
Last First MI

Address: _____
Street City State Zip

Mother's Information

Name: _____

Address _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Employer: _____

Father's Information

Name: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Employer: _____

Emergency Contacts (Other than parents):

_____ Phone _____
First and Last Name

_____ Phone _____
First and Last Name

I give the following people authorization to pick up my child:

_____ Phone _____
First and Last Name

_____ Phone _____
First and Last Name

People that are NOT authorized to pick up my child are: _____

Allergies or other important medical information (please include any limitations, medications, or special instructions)



Infant Social Resume

Please fill out completely and legibly.

CHILD'S INFORMATION

Name _____

(First Name)

(Middle Name)

(Last Name)

Date of Birth ____ - ____ - ____ Age ____ Sex Male Female

Does your child have a nickname? Yes No *If yes, what is it?* _____

FAMILY INFORMATION

Names of others living in the home	Birth date(s) / Age(s)	Relation to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FEEDING

Is your child breast fed? Yes No

If yes,

Do you plan to continue breast feeding? Yes No

If yes, how do you plan to carry this out? _____

What's your child's feeding schedule? _____

Do you supplement? _____

Is your child bottle fed? Yes No

What is your child's bottle feeding schedule?

	Amount	How often?	Comments
Breast Milk	_____	_____	_____
Formula	_____	_____	_____
Milk	_____	_____	_____
Water	_____	_____	_____

What position does your child like to be in while bottle feeding? _____

What position does your child like to be in while being burped? _____

Does your child have any food sensitivities or allergies? Yes No

If yes, please identify: _____

SLEEPING/NAPPING

BEDTIME When is their bedtime? _____ When do they wake up? _____
Where do they sleep? _____
What is your procedure for putting them to sleep? _____

NAPS When do they nap? _____ How long do they nap? _____
Where do they nap? _____
Does your child usually cry when going to sleep? Yes No
If yes, for how long? _____

SOCIAL/EMOTIONAL DEVELOPMENT

Describe your child's temperament: (example; colic, likes to cuddle)

What signs does your child give of being... (example; pulls at ears, rubs eyes, etc.)
Hungry _____
Tired _____
Over stimulated _____
Sick _____

Does your child separate easily from you? Yes No
Please comment: _____

Is your child afraid of anything? Yes No
Please comment: _____

Does your child have a favorite toy, blanket or soother? Yes No
Please comment: _____

Does your child spend time with other children? Yes No
Please comment: _____

What activities does your child enjoy? _____

What activities does your child dislike? _____

OTHER INFORMATION

Please provide any other information relating to your child that would be helpful in understanding and caring for your child. _____

PARENT SIGNATURES

Parent/Guardian Signature _____ Date _____
Parent/Guardian Signature _____ Date _____

