

Child's full name \_\_\_\_\_ Nickname \_\_\_\_\_ Birthdate \_\_\_\_\_ Gender - M F

Home Phone \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

**Parent or guardian enrolling child:** Full name \_\_\_\_\_ Relationship \_\_\_\_\_

Daytime phone # \_\_\_\_\_ Other phone # \_\_\_\_\_ Place of work \_\_\_\_\_

Home address & phone (if different from child) \_\_\_\_\_ phone \_\_\_\_\_

E-mail \_\_\_\_\_ Is this a good way to reach you? Yes \_\_\_ No \_\_\_

**Other Parent or Guardian:** Full name \_\_\_\_\_ Relationship \_\_\_\_\_

Daytime phone # \_\_\_\_\_ Other phone # \_\_\_\_\_ Place of work \_\_\_\_\_

Home address & phone (if different from child) \_\_\_\_\_ phone \_\_\_\_\_

**Other persons** In case of an emergency and parent/guardian cannot be reached, please list two other people who can be called for assistance. Select people who live in the area and have transportation. Make sure you discuss their responsibilities as emergency numbers. Please inform them that they will need to provide a picture I.D. in order to pick up your child:

Name \_\_\_\_\_ Day time Phone \_\_\_\_\_ Relationship to child \_\_\_\_\_  
(ex., Aunt, friend, etc.)

Name \_\_\_\_\_ Day time Phone \_\_\_\_\_ Relationship to child \_\_\_\_\_

**Health & Medical Info:**

Child's Physician/Source of Medical care \_\_\_\_\_ Phone \_\_\_\_\_

Child's Dentist/Source of dental care \_\_\_\_\_ Phone \_\_\_\_\_

Does child have any known allergies? Yes \_\_\_ No \_\_\_ If yes, documentation must be provided that lists each allergen and states the required response if the child is exposed to the allergen. A doctor's statement is preferred and may be required.

Current medications \_\_\_\_\_

Health or dietary restrictions or other pertinent facts: \_\_\_\_\_

\_\_\_\_\_ (use other side, if needed)

**I need your permission to apply any topical ointments. I will provide first aid cream and antibiotic ointment. Parents should provide other products, diaper cream/sunscreen they wish to be used on their child, but I will keep some backup supplies on hand. Please give or deny your consent by checking an answer for each of the following products:** Sunscreen Yes \_\_\_ No \_\_\_ Only What I provide \_\_\_ Diaper Ointment Yes \_\_\_ No \_\_\_ Only What I provide \_\_\_  
First Aid/Antibiotic ointment Yes \_\_\_ No \_\_\_ Only What I provide \_\_\_ Dry skin lotion Yes \_\_\_ No \_\_\_ Only What I provide \_\_\_

**Please answer questions, read agreement and sign below**

Yes \_\_\_ No \_\_\_ I authorize the use of photos from the program that include my child (no names are used) in the program's brochures or web page.  
Yes \_\_\_ No \_\_\_ I consent to listing our phone number in the program's Parent/Child Directory.

**By my signature I attest that:**

- In case of accident or injury, I authorize my child to be transported by ambulance and to receive any and all emergency medical, dental and/or surgical care and hospitalization advised by the physicians named on this card or at St Elizabeth's Hospital that are necessary for the proper health and well-being of my child;
- I have provided information concerning my child's special needs (Allergies, Diet, Disabilities, and/or Medical Information) to the program as may be necessary to assist the facility in properly caring for my child and in case of an emergency.
- I consent to the enrollment of the child listed above in the above GFDC.

Signature of a custodial parent or guardian \_\_\_\_\_ Date \_\_\_\_\_ Other parent or guardian signature (optional) \_\_\_\_\_ Date \_\_\_\_\_

Start Date \_\_\_\_\_ Please circle appropriate choice: 5 Days a week / 4 Days a week / 3 Days a week