**DIRECTOR'S USE ONLY**
Date enrolled:_____

HARBOR VIEW
CREATIVE LEARNING CENTER

## 2024 Enrollment Records

Child's Name: _____ Date of Enrollment: _____

Home Address: _____

Home Phone: _____ Sex: M F Age: _____ Date of Birth: _____

Child lives with: _____

Mother or Guardian's Name: _____

Address if different from child's: _____

Zip: _____ Home Phone: _____ Cell Phone: _____ Email: _____

Name of Employment (Mother/Guardian): _____

Address of Employment: _____ Work Phone: _____

Father or Guardian's Name: _____

Address if different from child's: _____

Zip: _____ Home Phone: _____ Cell Phone: _____ Email: _____

Name of Employment (Father/Guardian): _____

Address of Employment: _____ Work Phone: _____

Custody: Mother_____Father:_____Both:_____ Other:_____Name:_____

Special instructions for reaching parent or guardian: _____

Primary Hours of Care: From_____To_____Days of Week in Care:_____

C-0030 Required (Rev 3/20)

**Emergency Contacts: Child will be released only to the custodial parent or legal guardian and the persons listed below. The following people will also be contacted and are authorized to remove the child from the children's center in case of illness, accident or emergency, if for some reason the custodial parent(s) or legal guardian(s) cannot be reached:**

1. Name: _____ Home Phone: _____ Address: _____
   Work Phone: _____ Relationship to child: _____

2. Name: _____ Home Phone: _____ Address: _____
   Work Phone: _____ Relationship to child: _____

## Child Pick Up Information

Persons Authorized to pick up your child (Must show photo ID)

Name: _____

Home Phone: _____ Work Phone: _____

Name: _____

Home Phone: _____ Work Phone: _____

Name: _____

Home Phone: _____ Work Phone: _____

Child's Physician/Health Resource: _____ Telephone Number: _____

Street Address (number, apartment #, street): _____

City: _____ State: _____ Zip Code: _____

Hospital Preference: _____ Name of Dentist: _____

Telephone: _____ Address: _____

Street Address (number, apartment #, street): _____

City: _____ State: _____ Zip Code: _____

Chronic Medical Conditions: _____

Does your child have a Medical Action Plan? Yes No

If yes, the Medical Action Plan is for:

- ☐ Allergy & Anaphylaxis (Non-Food)
- ☐ Asthma
- ☐ Diabetes
- ☐ General (explain: _____)
- ☐ Seizure
- ☐ Food Allergy

If yes, the Medical Action Plan must be provided on or before the first day the child is in care.

Is your child fully immunized? _____

Complete immunization records must be provided on or before the first day the child is in care.

Food Allergies: _____

## Health History

(Chronic or Recurring)

Ear Infections: _____

Diabetes: _____

Heart disease/defect: _____

Convulsions/seizures: _____

Asthma: _____

Nosebleeds: _____

Measles: _____

Mumps: _____

Chicken Pox: _____

Flu or Flu Shot: _____

## Allergies

(Nature of Reaction)

Hay Fever: _____

Plant Poisoning: _____

Insect Stings: _____

Penicillin: _____

Other drugs: _____

Animals: _____

Food: _____

Other: _____

Operations or serious injuries (dates): _____

Is the child on any medications? (Explain): _____

If yes, please describe: _____

Physical Limitations: _____ Describe if yes: _____

Dietary Limitations: _____ Describe if yes: _____

Vision: _____ Hearing: _____

Are there any activities that you prefer that your child **NOT** participate in? If so, please list:

_____

I hereby give permission to Harbor View Creative Learning Center to call a doctor or emergency medical services and for the doctor, hospital or medical service to provide emergency medical or surgical care for my child_____.

It is understood that the childcare provider will make a conscientious effort to locate the parent/guardians and emergency contacts listed on the registration document before any action is taken. If it is not possible to locate emergency contacts that are listed, treatment will not be delayed.

I/we will accept the expense of any emergency transportation, medical or surgical treatment.

Parent/Guardian Signatures:

_____ Date: _____

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of emergency. In an emergency, other children in the facility will be supervised by a responsible adult. I will not administer any drug or any medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian.

Owner/Director Signature:

_____ Date: _____

**My signature below verifies that:**

**I give permission to consult the child's physician/health resource listed above in case of emergency if parent/legal guardian cannot be reached.**

**I have received a copy of the "Know Your Child's Children's Center" brochure.**

**I was notified in writing of the disciplinary and expulsion policies used by the children's center.**

**I was provided with the food and nutrition policies used by the children's center.**

**Your signature below indicates that you have received the above items and that the information on this enrollment form is complete and accurate. I hereby grant permission for the staff of this facility to have access to my child's records.**

**Signature of Custodial Parent or Legal Guardian:_____Date:_____**