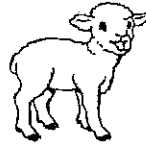


The Shepherd's Lambs Child Care Center

4240 Gettysburg Ave N.
New Hope, MN 55248
(763) 533-0600 ext. 209



Child Registration Forms

Child's Full Name : _____ Birth Date: _____

Home Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____

Nicknames: _____ Child Care Start Date: _____

PARENT INFORMATION

Mother's Full Name: _____ Birth Date: _____

Mother's Home Address: _____

City : _____ State: _____ Zip Code: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

Occupation: _____ Name of Employer: _____

Drivers License Number: _____

Father's Full Name: _____ Birth Date: _____

Father's Home Address: _____

City : _____ State: _____ Zip Code: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

Occupation: _____ Name of Employer: _____

Drivers License Number: _____

Parents are: Married _____ Divorced _____ Separated _____ Widowed _____ Single _____

Parent or Guardian with Legal Custody: _____

Religion: _____ Home Congregation: _____

Has your child been baptized? Y / N Date of Baptism: _____

Other Household Members:

Name: _____ Age: _____ Relationship to Child: _____

Name: _____ Age: _____ Relationship to Child: _____

Name: _____ Age: _____ Relationship to Child: _____

Name: _____ Age: _____ Relationship to Child: _____

Name: _____ Age: _____ Relationship to Child: _____

Emergency Contacts –Incase of Emergency – ie: extreme illness, etc.

(Must have all spots filled out and the person must be able to pick up the child with in an hour of being contacted.)

Primary Emergency Contact : (other than Parent or Guardian)

Name: _____ Relationship to Child: _____

Address: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

Secondary Emergency Contact : (other than Parent or Guardian)

Name: _____ Relationship to Child: _____

Address: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

Authorized to Pick Up My Child – Must submit 2 people.

Are able to pick up child at any time besides parents, guardians or emergency contacts.

Authorized to Pick Up Child #1:

Name: _____ Relation to Child: _____

Address: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

Authorized to Pick Up Child #2:

Name: _____ Relation to Child: _____

Address: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

Authorized to Pick Up Child #3:

Name: _____ Relation to Child: _____

Address: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

KID CODE: _____ (For preschool parents and children – secret word.)

Emergency Release

Consent to Emergency First Aid and Transportation

I hereby give my permission that my child _____, may be given emergency first aid by a staff member of The Shepherd's Lambs Child Care Center. I also give my permission for my child to be transported by car or ambulance to an emergency center for treatment, and will not hold The Shepherd's Lambs Child Care Center or its employees responsible.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Consent to Medical Care and Treatment

In the event that I cannot be contacted immediately, medical or surgical treatment can be administered to my child in case of an accident or emergency as prescribed by a treating physician, and I will not hold The Shepherd's Lambs Child Care Center or its employees responsible.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Emergency Information

Child's Physician: _____ Phone Number: _____

Address of Physician: _____

Preferred Hospital or Clinic: _____

Address of Hospital or Clinic: _____

Dentist: (Must submit preferred Dentist, even if child has not seen one yet.)

Name of Dentist: _____ Phone Number: _____

Address of Dentist: _____

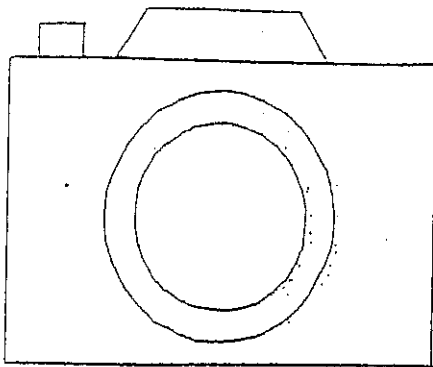
Insurance Company: _____ Policy Number: _____

Regular Medications your child needs: _____

Blood Type: _____ Allergies: _____

Date of Last Physical Exam: _____

Any other important medical information we should know?: _____



Address: _____

Home Telephone: _____

Father's Full Name: _____

Mother's Full Name: _____

Note Special Parent/Guardian Information:

Last Name: _____

First Name: _____

Age: _____

Emergency Information Form

Child's Full Name: _____ Date of Birth: _____

Height: _____ Date Measured: _____

Weight: _____ Date Weighed: _____

Date of Last Physical: _____ Physician's Name: _____

Place of Care: _____ Physician Contact #: _____

Allergies (medications, food, environmental, etc.): _____

Medical Conditions: _____

Current Medications: _____

Why: _____

EMERGENCY CONTACTS

#1 Name: _____ Relationship: _____

Primary Phone #: _____ Secondary #: _____

#2 Name: _____ Relationship: _____

Primary Phone #: _____ Secondary #: _____

#3 Name: _____ Relationship: _____

Primary Phone #: _____ Secondary #: _____

Any Additional Information: _____

Parent/Guardian Signature: _____

Date: _____