



LITTLE EXPLORERS
Learning Center

PRE-REGISTRATION INFORMATION

Registration Fee is required when this form is returned to the center. No spots will be held without fee being paid.

CHILD:

First name:	Middle name:	Last name:	Height: ft. in
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			
Nickname:			
Birthdate:			Weight: lbs.
Street Address:			Hair Color:
City:	State:	Zip: -	Eye Color:
Home Phone: () -			Distinctive Marks:

DOCTOR'S NAME:		DENTIST'S NAME:
Address:	Street:	Street:
	City: State: Zip: -	City: State: Zip: -
Telephone Number:	() -	() -
Hospital Preference:		

CHILD MEDICAL HISTORY:

Allergies:	Speech, Hearing, Vision Problems:
Surgical History:	Any current health problems:
Any special medications and/or restrictions:	Dietary Needs:

Has child had any of the following illnesses?			Is your child prone to:		
Chicken pox	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Ear infections	<input type="checkbox"/> YES	<input type="checkbox"/> NO
German Measles	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Stomach upsets	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Scarlet Fever	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Measles	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Headaches	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Mumps	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Colds	<input type="checkbox"/> YES	<input type="checkbox"/> NO
German Measles	<input type="checkbox"/> YES	<input type="checkbox"/> NO	URI	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Whooping Cough	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Sore throats	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Rubella	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Heart disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Rheumatic Fever	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Other:	<input type="checkbox"/> YES	<input type="checkbox"/> NO

PARENTS: Married Divorced Separated Widowed Single

If parents divorced, custody is with: Both parents Mother Father Legal Parent/Guardian

	Parent/Guardian 1	Parent/Guardian 2
Name:		
Home Phone:	() -	() -
Work Phone:	() -	() -
Cell Phone:	() -	() -
Email:		
Home Address:	Street:	Street:
	City: State: Zip: -	City: State: Zip: -
Employer:		
Work Address:	Street:	Street:
	City: State: Zip: -	City: State: Zip: -

Parent Work Schedule:		From	To		From	To
	Monday			Monday		
	Tuesday			Tuesday		
	Wednesday			Wednesday		
	Thursday			Thursday		
	Friday			Friday		

EMERGENCY CONTACT INFORMATION:

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 facility in case of illness, accident or emergency, if for some reason, the custodial parent or legal guardian cannot be reached:

	Emergency Contact 1	Emergency Contact 2
Name:		
Relationship to child:		
Address:	Street: City: State: Zip: -	Street: City: State: Zip: -
Home/Cell Phone:	() -	() -
Medical Decisions:	Authorized to make medical decisions <input type="checkbox"/> YES <input type="checkbox"/> NO	Authorized to make medical decisions <input type="checkbox"/> YES <input type="checkbox"/> NO

PICK-UP INFORMATION:

The following people **HAVE** permission to pick-up my children named below from Little Explorers Learning Center. It is the parent's responsibility to notify me in writing of any changes.

	Person 1:	Person 2:
Name:		
Relation:		
Address:	Street: City: State: Zip: -	Street: City: State: Zip: -
Home:	() -	() -
Work:	() -	() -
Cell:	() -	() -
Email:		
	Person 3:	Person 4:
Name:		

Relation:		
Address:	Street: City: State: Zip: -	Street: City: State: Zip: -
Home:	() -	() -
Work:	() -	() -
Cell:	() -	() -
Email:		

The following people *MAY NOT* pick-up my children:

	Person 1	Person 2
Name:		
Relation:		

Days child will attend: MON TUE WED THU FRI

Expected Arrival Time: _____ **Expected Departed Time:**

What date would you like to start childcare services? _____

This form is legally binding, so by signing it, you agree that all of the information provided herein is correct. False

Parent/Guardian's Signature	Date
Parent/Guardian's Signature	Date
Signature of Director	Date

Information may result in termination of childcare services.