Pinnacle Cub's Den

ENROLLMENT RECORD

Date of Enrollment_____

Child's Name _____

Home Address _____

Home/Cell Phone _____**Sex M / F Age** _____**Date of Birth**_____

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 (mother/guardian) _____**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 (father/guardian) _____**Work Phone**_____

Special instructions for reaching parent or guardian

_____

EMERGENCY CONTACTS

Name_____**Home/Cell Phone**_____

Address_____

Work Phone_____ **Relationship to child** _____

Name _____**Home/Cell Phone**_____

Address_____

Work Phone _____ **Relationship to child** _____

CHILD PICK UP INFORMATION

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

Name_____**Relationship to child**_____

Home/Cell Phone_____**Work Phone**_____

Name_____ **Relationship to child**_____

Home/Cell Phone_____ **Work Phone**_____

Name_____**Relationship to child**_____

Home/Cell Phone_____**Work Phone**_____

Name_____**Relationship to child**_____

Home/Cell Phone_____**Work Phone**_____

Name, address and phone number of child's doctor _____

_____

Name, address and phone of child's dentist _____

_____

Hospital of Preference_____**Address**_____**Phone**_____

Chronic Medical conditions _____

_____

Does your child have a health care plan? _____
If yes, the health care plan must be provided on or before the first day the child is in care.

Is your child fully immunized? _____
If yes, the health care plan 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_____
Convulsion/seizures_____
Asthma _____
Nosebleeds_____
Measles_____
Mumps_____
Chicken Pox _____

ALLERGIES

(Nature of Reaction)
Hay Fever_____
Plant Poisoning_____
Insect stings_____
Penicillin_____
Other drugs_____
Animals_____
Food_____
Other_____

Flu shot Yes _____No_____If Yes When?_____

Operations or serious injuries (dates) _____

_____

Is the child on any medications? _____

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 <u>NOT</u> participate in? _____

If so please list: _____

_____

_____

Authorization for Emergency Medical Care

I hereby give my permission to CUB'S DEN to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide emergency medical or surgical care for my child,_____

It is understood that the child care provider will make a conscientious effort to locate the parent/guardians and emergency contacts listed on the registration document before any action will be taken. If it is not possible to locate emergency contacts listed treatment will not be delayed. I/we will accept the expense of emergency transportation, medical or surgical treatment.

Parent/Guardian Signature_____Date_____