



## 2026-2027 REGISTRATION FORM

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Gender:  Male  Female Race: \_\_\_\_\_

### Class for the Program Year ( August-July)

Class Type:  Infant  Transitional Toddler  Rising 2  K-2  Rising 3  K-3

Parent /Guardian's Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email \_\_\_\_\_

Parent /Guardian's Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email \_\_\_\_\_

### Emergency Contact Information

Emergency Contact Name \_\_\_\_\_  
Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

### Emergency Contact Information

Emergency Contact Name \_\_\_\_\_  
Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

### Emergency Contact Information

Emergency Contact Name \_\_\_\_\_  
Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

**Health Information**

- Do you have any existing medical conditions or needs that we should be aware of? \_\_\_\_\_
- Please list all medications your child is currently taking \_\_\_\_\_
- To my knowledge, my child is healthy and able to function in group care. \_\_\_\_\_

**Signature**

Does your child have asthma or has he been prescribed an fast acting inhaler?  YES  NO

Does your child have severe allergies or has he been prescribed an epi pen?  YES  NO

Has your child ever suffered a seizure?  YES  NO

Has your child ever been hospitalized?  YES  NO

Has your child ever suffered a diabetic emergency?  YES  NO

Is your child allergic to anything?  YES  NO

**If you answered yes to any question, please explain:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Pediatrician \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Hospital Preference \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Phone Number \_\_\_\_\_

Policy # \_\_\_\_\_

Insured \_\_\_\_\_ Phone Number \_\_\_\_\_

**Approved Pick Up**

Approved Pick up Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

**Approved Pick Up**

Approved Pick up Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_