



Child Enrollment and Authorization Form

Child's Name _____	Date Entered Care _____
Child's Nickname _____	Age at Entry to Care _____
Birthdate ____/____/____	

ALLERGY ALERT: Does child have allergies? **YES** **NO** If yes, list all allergies on back side of form.

Parent or Guardian Contact Information

Name (first, last)	Relationship
Street Address	City Zip
Home Phone	Cell Phone
Employer and Work Hours	Work Phone
Name (first, last)	Relationship
Street Address	City Zip
Home Phone	Cell Phone
Employer and Work Hours	Work Phone

Required Emergency Contact Information-person other than parent or guardian that is authorized to pick up child

Name (first, last)	Phone	Relationship
Name (first, last)	Phone	Relationship

Non-Emergency Contact Information-person other than parent or guardian that is authorized to pick up child

Name (first, last)	Phone	Relationship
Name (first, last)	Phone	Relationship

Medical/Dental Contact Information

Insurance Provider and Policy Information (if applicable)	
Primary Physician Name	Phone
Dental Provider (if child is school-age. If none, list dental provider for child care facility)	Phone

Parent or Guardian Authorization

Please list any restrictions to permission of the following:

- My child** may be taken on walking excursions under required supervision.

- My child** may be photographed for publicity or news purposes On-site Off-site

- My child** may be given non-prescribed medication as indicated on the container. This may include sunscreen, children’s pain reliever, and antibacterial first aid cream. Syrup of ipecac may be administered if deemed necessary by the poison control operator. The child’s parent or guardian will be contacted prior to administering non-prescription pain relievers. Prescription medications must be current and a permission slip is required per each medication.

In an emergency, Little Wellspring staff has my permission to call an ambulance, or take my child to any available physician or hospital at my expense to obtain medical treatment. In most emergencies, 911 is called and the child is transported to the nearest hospital and treated by the on-call physician. The parent or guardian of the child is notified as soon as possible.

Parent/Guardian Signature _____ **Date** _____

Need Care for the Following Times:

Full Time

- 5 Days/Week (M-F)
- 3 Days/Week (MWF)
- 2 Days/Week (TTH)

Part Time (8:30 a.m.-12:30 p.m.)

- 5 Days/Week (M-F)
- 3 Days/Week (MWF)
- 2 Days/Week (TTH)



Child Information

Has your child previously been in child care?		If yes, what type of care and for how long?	
Reason for requesting care			
Child General Information —please include all information that will assist us in providing quality care for your child			
Likes and Dislikes			
Eating Habits and Schedule			
Sleeping Habits and Schedule			
Play			
Fears			
Special Words and their Meanings			
Child Medical Information			
Does your child have allergies?		Has your child had chickenpox?	
Yes	No	Yes	No
List all allergies or other health problems, including instructions for providing best possible care in regard to stated conditions. Do any of the medical conditions restrict the child's activities?			
Other Children in Home			
Name (first, last)	Nickname	Age	Sex
Name (first, last)	Nickname	Age	Sex
Name (first, last)	Nickname	Age	Sex
Name (first, last)	Nickname	Age	Sex

Parent/Guardian Signature _____ Date _____