



# HILLTOP CHILD CARE CENTER

## Registration/Emergency Form

### CHILD

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_ Birth date: \_\_\_\_\_ Start Date: \_\_\_\_\_

Names of Siblings in Center: \_\_\_\_\_

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### PARENTS OR GUARDIAN

Mother's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt # \_\_\_\_\_ City: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

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Father's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt # \_\_\_\_\_ City: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

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### OTHER EMERGENCY CONTACTS

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_

AUTHORIZATION FOR PICKUP

Your child will only be released to an authorized person listed on this form. In case of an emergency or an unforeseen circumstance, please indicate the name and phone number of any other person(s) who you authorize to pickup your child on your behalf

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

A parent/guardian's verbal authorization for pickup must be received before your child will be released to anyone not listed here. If not received, and we cannot notify you by phone, the child will not be released

MEDICAL INFORMATION

Child's Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medical Problems: \_\_\_\_\_

Medications: \_\_\_\_\_

IMMUNIZATION/ PHYSICAL RECORDS

The Health Department requires that we have current copy of your child's 680 form (shot record) and a current physical. Please include a copy with this registration form

EMERGENCY CONSENT

It is our policy to notify a parent when a child is ill or need medical attention. Occasionally, we cannot contact a parent and we need to get immediate help for the child. Our procedure is to take the child tot the nearest emergency service. Please sign below so that we can take appropriate action on behalf of your child

I HEREBY GIVE MY/OUR CONSENT FOR MY/OUR CHILD \_\_\_\_\_ WHEN ILL/INJURED, TO BE TAKEN TO \_\_\_\_\_ HOSPITAL BY ONE OF THE STAFF OF MY CHILD'S CHILD CARE CENTER WHEN I/WE CANNOT BE CONTACTED. I CONSENT TO ANY AMBULENCE BEING CALLED TO TRANSPORT THE CHILD, IF NECESSARY, I FURTHER AGREE TO PAY CALL COST INCURRED FOR TRANSPORT

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# PARENT CHECKLIST

Hilltop Child Care Center

- According to county regulations, I understand that I must be responsible for my child's nutritional and dietary needs for all meals
  
- I have received a copy of the Child Care facility brochure (Chapter 402.31255, F.S.)
  
- DISCIPLINE  
The children will only be disciplined in a constructive manner. It is understood that this center employs only the "time out" method of discipline. By which a child is requested to move out of the group or activity. This is to give a child time to think about their inappropriate behavior before rejoining the group. At all times, they remain in the staff or school responsibility in any way in case of accident
  
- FIELD TRIP PERMISSION  
I hereby give my permission for the school to take my child on all field trips and off activities. Advance notice will always be given for these field trips. I realize the every precaution will be taken for my child's safety at school or away. I will not hold members of the staff or responsible in any way in case of accident
  
- AUTHORIZATION FOR EMERGENCY MEDICAL CARE  
Parents and Guardian agree to accept the insurance as provided by or through the school as the total liability of the school. The school is hereby authorized to obtain emergency medical are in case of the parents or guardians cannot be reached. Authorization is given to utilize the service of any qualified physician to treat their child in the event of such an emergency

PEDIATRICIAN \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_

SIGNATURE OF PARENT \_\_\_\_\_ DATE \_\_\_\_\_

WITNESSED BY \_\_\_\_\_ DATE \_\_\_\_\_

