

**STAFFORD CHILDREN'S CENTER**

**ADMISSION FORM**

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Father's Cell: \_\_\_\_\_ Mother's Cell: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Father's Work: \_\_\_\_\_ Mother's Work: \_\_\_\_\_

Father's Work Phone: \_\_\_\_\_ Mother's Work Phone: \_\_\_\_\_

**Emergency Contact:**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

**PLEASE LIST PEOPLE AUTHORIZED TO PICK UP YOUR CHILD:**

NAME: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

**CHILD HEALTH INFORMATION:**

DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

DENTIST: \_\_\_\_\_ PHONE: \_\_\_\_\_

Does your child have allergies? \_\_\_\_\_

Is your child on medication? \_\_\_\_\_

Does your child have any special needs? \_\_\_\_\_

I have provided my child's immunization records and will send in updated copies as they occur. My child's caregivers have permission to provide and secure emergency care in my absence including transportation to the area hospital until the time in which I can reach my child, I understand I will be contacted immediately if such care is needed. I have received a copy of the center handbook and agree to the conditions therein.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Admission Date: \_\_\_\_\_ Withdrawal Date: \_\_\_\_\_