

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 _____ PHONE _____

NAME: _____ RELATIONSHIP _____ PHONE _____

NAME: _____ RELATIONSHIP: _____ PHONE _____

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: _____