



Registration Form

Date _____
 Registration paid by Cash/Charge

If we can't read it, we can't enter it. **Please** print neatly!

Guardians Circle Relationship: Parent Grandparent Step-Parent Foster Parent Relative Friend

1 First Name _____ Last Name _____ Home(____) _____
 Address _____ Apt # _____ Cell (____) _____
 City _____ State ____ Zip _____ Driver 's License _____ State _____ Work (____) _____
 Email to receive coupons and announcements. (Emails will not be shared.) _____

In lieu of picture identification at time of pick-up, please give us a password _____

2 First Name _____ Last Name _____ Home(____) _____
 Address if different _____ Apt # _____ Cell (____) _____
 City _____ State ____ Zip _____ Driver 's License _____ State _____ Work (____) _____
 Children's Doctor Name/Phone _____ (____) _____
 Children's Dentist Name/Phone _____ (____) _____

Emergency Contacts Must list at least one contact other than parents as an Emergency Contact.

1 First Name _____ Last Name _____ Home(____) _____
 Address _____ Apt # _____ Cell (____) _____
 City _____ State ____ Zip _____ Driver License # _____ State _____ Work (____) _____
 Circle Relationship: Parent Grandparent Step-Parent Foster Parent Relative Friend

2 First Name _____ Last Name _____ Home(____) _____
 Address _____ Apt # _____ Cell (____) _____
 City _____ State ____ Zip _____ Driver License # _____ State _____ Work (____) _____
 Circle Relationship: Parent Grandparent Step-Parent Foster Parent Relative Friend

People Authorized for Pick-up

1 _____ 2 _____
 3 _____ 4 _____

Children Enter names as you would like them to appear on their name tags - nicknames are fine.

First Name						
Last Name						
Sex	Boy	Girl	Boy	Girl	Boy	Girl
Birth Date						
Hygiene	Diapers	Remind	Trained	Diapers	Remind	Trained
1. Food allergies or restrictions?	Yes	No		Yes	No	Yes No
2. Medicine allergies?	Yes	No		Yes	No	Yes No
3. Insect bite allergies?	Yes	No		Yes	No	Yes No
4. Other allergies?	Yes	No		Yes	No	Yes No
5. Takes medications?	Yes	No		Yes	No	Yes No
6. Asthma?	Yes	No		Yes	No	Yes No
7. Hearing/vision problems?	Yes	No		Yes	No	Yes No
8. Past health problems?	Yes	No		Yes	No	Yes No
9. Activity restrictions?	Yes	No		Yes	No	Yes No
10. Special routines	Yes	No		Yes	No	Yes No
11. Usually takes a nap?	Yes	No		Yes	No	Yes No

Explain any Yes answers. List by child's name and question number.

Signature _____ Date _____

Registration will remain active unless there are no visits for 12 months.

