Enrollment Record

Please fill out in full detail.

Contact Information

Date of Enrollment: DD-MM-YYYY

Child's Name*

Nickname*

Date of Birth*
DD-MM-YYYY

Allergies*

Home Address*

City*

State*

Zip*

Best Contact Number:*

Best Email Address*

Mother or Guardian

Name*

Mobile Number*

Email*

Home Address (if different)*

City*

State*

Zip*

Home Phone

Name of employment (mother/guardian)*

Work Phone*

Address of employment (mother/guardian)

Father or Guardian

Name*

Mobile Number*

Email*

Home Address (if different)*

City*

State*

Zip*

Home Phone*

Name of employment (mother/guardian)*

Work Phone*

Address of employment (mother/guardian)*

Enrollment Record

Please fill out in full detail.

Emergency Contacts

Emergency Contact #1 Name*

Relationship to Child*

Best Contact Number*

Address*

Emergency Contact #2 Name*

Relationship to Child*

Best Contact Number*

Address*

Persons authorized to pick up your child (Must Show Photo ID)

Pickup Authorized #1 Name*

Relationship to Child*

Best Contact Number*

Address*

Pickup Authorized #1 Name*

Relationship to Child*

Best Contact Number*

Address*

Medical Information

Primary Care Doctor Name/Practice*

Phone Number*

Address*

Dentist Name/Practice*

Phone Number*

Address*

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Preferred Hospital (check one)

- [x] Memorial Hospital Main – 1400 Boulder St, (719) 365-5000
- [ ] Memorial Hospital North – 8890 Briargate Blvd, (719) 365-5000
- [ ] Penrose North Hospital – 2222 Nevada Ave, (719) 776-5000
- [ ] St. Francis Medical Canter – 6001 E. Woodmen Rd, (719) 570-1000
- [ ] Children's Hospital, Briargate - 4090 Briargate Pkwy, (719) 305-1234
- [ ] Other (Name, Address, Phone:

Does your child have a health care plan?

if yes, the health care plan must be provided on or before the first day of care.

- [x] Yes
- [ ] No

Is your child fully immunized?

Completed immunization records must be provided on or before the first day of care.
Please bring us all updated records after receiving new immunizations.

- [x] Yes
- [ ] No

Chronic or Recurring Health History

Ear Infections*

Diabetes*

Heart Disease/Defect*

Convulsions/Seizures*

Asthma*

Nosebleeds*

Insect Stings*

Medication/Drugs*

Food*

Other*

Please list any other chronic conditions*

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Nature & dates of any surgeries or severe injuries*

Is your child on any medications? (if yes, please explain)*

Does your child have any physical limitations? (if yes, please explain)*

Does your child have any dietary restrictions? (if yes, please explain)*

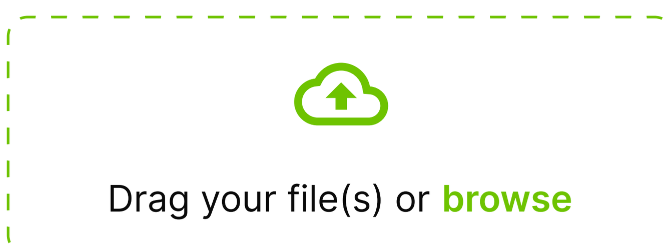
Please list any activities that you prefer your child NOT participate in*

Authorization for Emergency Medical Care

I hereby give my permission to Little Sprouts Learning Center to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide emergency medical or surgical care for my child, ______________________________.

It is understood that the childcare provider will make a conscientious effort to locate the parent/guardians and emergency contacts listed on the registration document before any action will be taken. If it is not possible to locate emergency contacts listed treatment will not be delayed. I/We will accept the expense of emergency transportation, medical or surgical treatment.

Upload

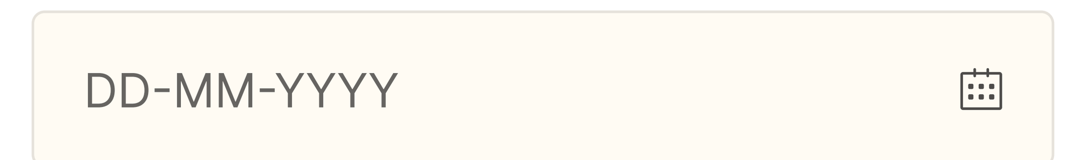


Date:

Parent/Guardian Signatures:

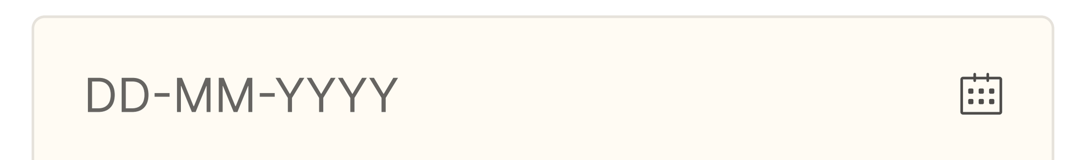
Print Name*

Date*

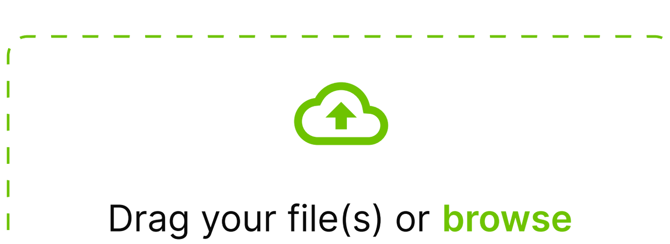


Print Name*

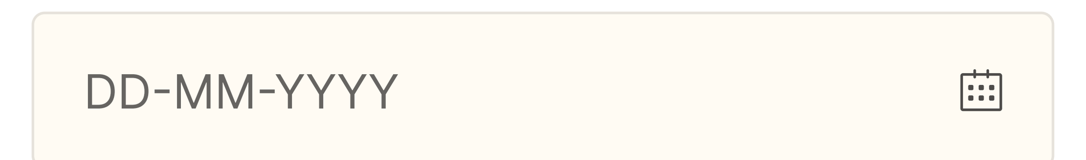
Date*



Director Signature*



Date*



Enrollment Record

Please fill out in full detail.

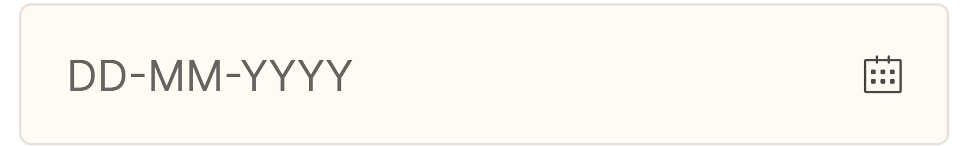
Contact Information (Classroom Copy)

Date of Enrollment:

Child's Name*

Nickname*

Date of Birth*



Allergies*

Mother or Guardian

Name*

Home Phone*

Cell Phone*

Work Phone*

Father or Guardian

Name*

Home Phone*

Cell Phone*

Work Phone*

Emergency Contacts

Emergency Contact #1 Name*

Relationship to Child*

Best Contact Number*

Address*

Emergency Contact #2 Name*

Relationship to Child*

Best Contact Number*

Address*

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