

# TAMARACK LEARNING CENTER CHILD CARE REGISTRATION FORM

Tentative Start Date: \_\_\_\_\_ Days attending: \_\_\_\_\_

Meals your child may be here for: Please circle (Breakfast) (Lunch) (Afternoon Snack)

What time will the child arrive? \_\_\_\_\_ depart? \_\_\_\_\_

Child's Full Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Best Email contact: \_\_\_\_\_ Child's Address: \_\_\_\_\_

Apt #, City, Zip: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_  
Month day year

Mother's name: \_\_\_\_\_ Father's name: \_\_\_\_\_

Mother's Address: \_\_\_\_\_ Father's Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Mother's email: \_\_\_\_\_ Father's email: \_\_\_\_\_

Mother's Cell #: \_\_\_\_\_ Father's Cell #: \_\_\_\_\_

Mother's occupation: \_\_\_\_\_ Father's occupation: \_\_\_\_\_

Place of employment: \_\_\_\_\_ Place of employment: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Working hours: \_\_\_\_\_ Working hours: \_\_\_\_\_

Other adults and/or children in household (name and relationship) \_\_\_\_\_

Who usually drops the child off? \_\_\_\_\_ Who usually picks the child up? \_\_\_\_\_

Name and relationship of all other persons who may be authorized to remove your child from center:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Address: \_\_\_\_\_

Has your child attended childcare previously? Name of center: \_\_\_\_\_ Home daycare? \_\_\_\_\_

In case of an emergency, parents cell/work #'s called 1st, if no answer, 2 other persons who can be called

are required by DHS & TLC. Parent must sign here: \_\_\_\_\_

Allowing the persons listed below, permission to pick up your child from TLC.

1. \_\_\_\_\_  
Name address Relationship Phone #

2. \_\_\_\_\_  
Name address Relationship Phone #

This form must be updated bi-annually at P/T conferences. All Information Kept Confidential.

1<sup>st</sup> Year update / Parent Signature: \_\_\_\_\_ & Date when updated: \_\_\_\_\_

2<sup>nd</sup> Year update - Parent Signature: \_\_\_\_\_ & Date when updated: \_\_\_\_\_

When Enrolled in a Dept. of Human Service Licensed Child Care Center (This info is required by MN DHS.)

Physician's name: \_\_\_\_\_ telephone #: \_\_\_\_\_

Physician's address: \_\_\_\_\_

Dentist name: \_\_\_\_\_ telephone #: \_\_\_\_\_

Dentist address: \_\_\_\_\_

By Signing the bottom of this Form, I hereby authorize the following physician and dentist to give emergency care to my child. If unavailable, another Licensed Physician or dentist may treat my child. (Both Required) ALSO, In case of an emergency, delay in pick-up or unable to pick child up, TLC has my permission to take action to assure the well being of my child.

Health Insurance Provider: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Policy #: \_\_\_\_\_ Date of Policy: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

My child's daily habits are: (please circle one or more that apply)

Communication: Non-verbal      Talks a little      Communicates well

Bathroom:      Diapers      Potty Training      Potty Trained

Meals:      Formula Only      Baby food      Some Table Foods      All Table Foods

Type of Fluid milk: \_\_\_\_\_ or Name of Formula: \_\_\_\_\_

Naps:      More than 1      1 a day      No nap

Please complete the following if you would like us to know this information: Family structure /

Traditions: \_\_\_\_\_ Race: \_\_\_\_\_ Religion: \_\_\_\_\_

Customs & Cultural preferences: \_\_\_\_\_

Language Preferred: \_\_\_\_\_ Interpreter will be provided upon request.

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

If needed, please attach an additional page for Comforting Methods, special needs, or any information we should know. Other Important Information: \_\_\_\_\_

If your child attends school, Please list name & phone # of school \_\_\_\_\_

TLC has my permission to administer to my child over the counter or prescription medication (with accurate pharmacy label) under the direction given in writing signed by only you (Parent or Guardian) and according to the label on the medication. No Exceptions!

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_