

REGISTRATION FORM

<i>KID SPACE</i> Drop-in Child Care		Director: Betsy Garrett Estrada
Child's Name:	Date of Birth:	Home Phone #:
Address:		
Date of Admission:		Hours child will be in care: [] Part-time [] Drop-in care only.
Parent's or Guardian's Name:		
Parent's or Guardian's Address (if different from child's):		
Mother's Phone #: Work: Cell:	Father's Phone #: Work: Cell:	Guardian's Phone #: Work: Cell:
Name of person to call if Parent or Guardian can't be reach:	Home phone #: Work: Cell:	Address: Relationship to Child:

My child is allowed to leave the childcare facility with the following persons ONLY:

Name/Phone #:	Name/Phone #:
Name/Phone #:	Name/Phone #:

I acknowledge receipt of Kid Space's Parent Brochure, Operational Policy and understand that all purchases and fees are neither refundable nor transferable:

Parent or Guardian Signature: _____ Date: _____

SCHOOL AGE CHILDREN:

My child attends the following school: _____

School Phone Number: (_____) _____ - _____

CHECK IF APPLICABLE:

[] His/Her immunization record is on file at the school and all immunizations are current.

Vision and Hearing screening records are also on file.

Signature: _____

Date: _____

List any special problems your child may have including any allergies, chronic illness, previous serious illness or injuries within the last 12 months, any long-term medication, and any other information you feel the staff should be aware of to help them better care for your child:

PLEASE ATTACH IMMUNIZATION RECORD WITH REGISTRATION

REGISTRATION FORM

<i>KID SPACE</i> Drop-in Child Care	Director: Betsy Garrett Estrada
--	---------------------------------

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event that I can not be reached to make arrangements for emergency medical attention, I authorize the person in charge to make such arrangements:

Physician:	Address:	Phone #
Hospital: North Central Baptist	Address: 520 Madison Oak, S.A. TX 78258	Phone #: (210) 297-4050

ADMISSION REQUIREMENT FOR CHILDREN UNDER AGE 5:

One of the following must be present for your child within one week of admission to the daycare facility:

HEALTH-CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he/she is physically able to take part in the daycare program.

Health Care Professional's signature: _____ Date: _____

PARENT'S STATEMENT: My child has been examined within the past year by a health care professional and is able to participate in the daycare program.

Name and Address of Health Care Professional: _____

Within 12 months of admission, I will obtain a Health Care Professional's statement and will submit it to the daycare facility.

SIGNATURE OF PARENT OR GUARDIAN: _____
Date: _____

I understand that the Director will be available to address any questions or concerns I may have concerning policies and procedures and that I will be notified in writing of any Center Policy changes.