



2012-2013 PROGRAM REGISTRATION

Child's Name: _____ Nickname: _____

Date of Birth: _____ Gender: M F Home Phone: _____

Chronic Physical Problems/Pertinent Developmental Information/Special Accommodations Needed:

Previous Child Day Care Programs and Schools Attended:

PARENT/GUARDIAN INFORMATION:

Mother/Guardian's Name: _____ Business Phone: _____

Place of Employment: _____ Job Title: _____

Home Address: _____ Home/Cell Phone: _____

Father's/Guardian's Name: _____ Business Phone: _____

Place of Employment: _____ Job Title: _____

Home Address: _____ Home/Cell Phone: _____

Person(s) or Agency Having Legal Custody of Child: _____

Home Address: _____ Home Phone: _____

Business Address: _____ Business Phone: _____

EMERGENCY CONTACT INFORMATION:

Allergies or Intolerance to Food, Medication, etc, AND action to take in an Emergency situation:

Child's Physician: _____ Phone: _____

TWO EMERGENCY CONTACTS: *(In case parent/guardian cannot be reached)*

Name: _____ Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name: _____ Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Person(s) Authorized to Pick-up Child: _____

Person(s) NOT Authorized to Pick-up Child*: _____

*Appropriate paperwork such as custody papers should be attached if a parent is not allowed to pick up the child.

AGREEMENTS:

1. The FFC Program agrees to notify the parent(s)/guardian(s) whenever the child becomes ill and the parent(s)/guardian(s) will arrange to have the child picked-up as soon as possible, if so requested by the Center.
2. The parent(s)/guardian(s) authorize the FFC program to obtain immediate medical care if any emergency occurs when parent(s)/guardian(s) cannot be located/contacted immediately. **
3. I agree to inform Fun Farm Center within 24 hours or the next business day after my child or any member of my immediate household has developed any reportable communicable disease, as defined by the State Board of Health, except for life threatening diseases which must be reported immediately.

****If there is an objection to seeking emergency medical care, a statement must be obtained from the parent(s)/guardian(s) that states the objection and the reason for such objection.**

Parent(s) or Guardian(s) signature

Printed Name and Date

Program Director

Date

Date Child Entered Program: _____ Date Child Left Program: _____

OFFICE USE ONLY—Identification Verification

For proof of child identity, please complete the following form original document:

Place of Birth: _____ Birth Date: _____

Certificate #: _____ Issue Date: _____

Person Viewing Document (Print Name and Signature): _____

Notification of Local Law-Enforcement Agency (when required proof of identity is NOT provided):

Date: _____ Initialed By: _____

Proof of the Child's identity and age may include a certified copy of the child's birth certificate, birth registration card, notification of birth (hospital, physician, or midwife record), passport, copy of the placement agreement or other proof of the child's identity from a child planning agency (I.e., foster care or adoption agencies) record from a public school in Virginia, certification by a principal or his designee of a public school in the U.S. that a certified copy of the child's birth record was previously presented, or copy of the entrustment agreement conferring temporary legal custody of a child to an independent foster parent. While programs are NOT required to keep the proof of the child's identity, documentation of viewing this information must be maintained by each child.