



Enrollment Form

Where Play & Discovery COLLIDE

CHILD'S INFORMATION			
Last Name:			
First Name:		Middle Name:	
Nick Name:			
Date of Birth:			
Name(s) of Sibling(s) and Date(s) of Birth:			
Primary Language of Child -			

PARENTS or GUARDIANS							
1. Last Name:				First Name:			
Relationship to Child:							
Address:							
City:				Postal Code:			
Home Phone:			Work Phone			Alt Phone:	
Email Address							
Employer:				Work Address:			
2. Last Name:				First Name:			
Relationship to Child:							
Address:							
City:				Postal Code:			
Home Phone:			Work Phone			Alt Phone:	
Email Address							
Employer:				Work Address:			

OTHER EMERGENCY CONTACT							
Name:				Relationship to Child			
Home Phone:			Work Phone			Alt Phone:	
Name:							
Home Phone:			Work Phone			Alt Phone:	

Your child will only be released to an authorized person listed on this form (parent/guardian and/or emergency contact). In case of an emergency or an unforeseen circumstance, please indicate the name, address, and phone number of any other person(s) whom you authorize to pick up your child on your behalf.

Other than yourself who has authorization to pick up Child (must be 18years or older)		
Name	Address	Phone
Who does <u>not</u> have authorization to pick up Child		
Name	Reason	

A parent/guardian's verbal authorization for pick-up must be received before your child will be released to anyone not listed here. If not received, and we will notify you by phone, that the child will not be released.

MEDICAL INFORMATION

Doctor:		Office Phone:	
Address:			
City:		Postal Code:	
Medical Insurance #:		Child's Personal #:	
ALLERGIES:			
MEDICAL PROBLEMS, LIMITATIONS or SPECIAL DIET:			
MEDICATION:			

ADMINISTER PRESCRIPTION MEDICINE

I/We authorize _____ to administer prescribed medicine to my/our child as specified in the prescription's directions for administration.

Date _____ Signature of parent _____

Relationship to Child _____

PERMISSION FOR WALKS, TRIPS and PUBLIC PARKS

I/we authorize _____ to take my/our child off the premises of the family child care home for the following : walking trips, special excursions, and to nearby public park facilities. I/we also authorize the child to ride as a passenger in the vehicle owned or leased by the above named person. I/we understand all such trips are under the supervision of the above named person and that health and safety precautions are taken in compliance with DCFS standards and licensure.

Date _____ Signature of parent _____

Relationship to Child _____

ADDITIONAL INFORMATION

Please indicate likes/dislikes, potty training, special interests, etc:

IMMUNIZATION

Your child’s recent immunization record is required, please include a photocopy with this registration form. If you do not have the records, a copy can be obtained from your local health unit.

EMERGENCY CONSENT

It is the policy of Lil’ Bebe Academy to notify a parent when a child is ill or needs medical attention. Occasionally, we cannot contact a parent and we need to get immediate help for the child. Our procedure is to contact persons on the Emergency contact form. If it is a case of serious illness the child will be transported to the nearest Emergency Center.

Please sign below so that we can take appropriate action on behalf of your child.

I HEREBY GIVE MY/OUR CONSENT FOR MY/OUR CHILD _____ WHEN ILL/INJURED, TO BE TAKEN TO THE NEAREST EMERGENCY CENTER BY **LIL BEBE ACADEMY** WHEN I/WE CANNOT BE CONTACTED. I/WE CONSENT TO AN AMBULANCE BEING CALLED TO TRANSPORT MY/OUR CHILD, IF NECESSARY. I FURTHER AGREE TO PAY ALL COSTS INCURRED FOR TRANSPORT.

The following needs to be accompanied with Enrollment form.

- copy of Child’s birth certificate or passport
- A recent photo of the Child
- Copy of parent’s driver license and any other authorized pick up person
- The Child’s most recent medical report (signed by a licensed Illinois pediatrician)

Parent / Guardian Signature:		Date:	
Parent / Guardian Signature:		Date:	

Lil Bebe Academy

Notes:

FOR OFFICE USE ONLY:

Emergency Card Information

Child's Name: _____ Date of Birth: _____

Child's Home Address: _____

_____ Phone: _____

How to Reach Parents or Guardian

1. _____
Name, Address, Cell and Home Phone #

2. _____
Name, Address, Cell and Home Phone #

Contact Information of Physician or Health Care Professional

Emergency Contact Person

1. _____

2. _____

Emergency Medical Treatment

I hereby give _____ permission to
Name of Provider / Provider Assistants

Administer basic first aid and CPR to my child _____ or to take my child
Name

To a hospital for medical treatment when I cannot reach parents or guardians / when child's health treatment is time sensitive.

Parent/ Guardian (Name and Signature) Date

Medical Insurance Information (Optional)

Subscribers _____

Type of Insurance eg. HMO/ PPO _____

Policy No. _____ Group No. _____