



PLEASE PRINT OR TYPE

REGISTRATION RECORD FOR CHILD RECEIVING CARE AWAY FROM HOME

Child: _____ Sex: Male Female
Last First M.I.
Date of Birth: _____ Home # _____ Language Spoken At Home _____
Home Address: _____
Number Street Apt. # State ZIP

Father: _____ Home # _____
Last First M.I. Business # _____
Home Address: _____
Number Street Apt. # State ZIP
Business Address: _____
Number Street Apt. # State ZIP

Mother: _____ Home # _____
Last First M.I. Business # _____
Home Address: _____
Number Street Apt. # State ZIP
Business Address: _____
Number Street Apt. # State ZIP

Relative or Guardian: _____ Home # _____
Last First M.I. Business # _____
Home Address: _____
Number Street Apt. # State ZIP
Business Address: _____
Number Street Apt. # State ZIP

Person to be contacted in case of an emergency (other than parent/guardian):
_____ Relationship to child: _____
Last First M.I.
Address: _____
Number Street Apt. # State ZIP Phone #

Designated individual authorized to receive child at end of session:

Last First M.I.

Last First M.I.

Last First M.I.

Signature: _____ Relationship to child: _____ Date: _____

TO BE COMPLETED BY THE FACILITY

Date of Admission: _____
Date of Withdrawal: _____ Reason: _____
PLEASE RETAIN A COPY FOR YOUR RECORDS