

		2009 – 2010 Child Admissions Application		Date Child Enrolled	Date Child Left Care
Child's Name	Last	First	Middle	Name Used	Birthdate
Street Address			City, State		Zip Code
Child's Parent/Guardian Name		10-Digit Home Telephone Number		10-Digit Telephone Number (Work)	
Street Address			City, State		Zip Code
Place of Business: Company Name & Address			City, State		Zip Code
E-mail Address		Cell Telephone Number		Occupation	
Child's Parent/Guardian Name		10-Digit Telephone Number		10-Digit Telephone Number (Work)	
Street Address			City, State		Zip Code
Place of Business: Company Name & Address			City, State		Zip Code
E-mail Address		Cell Telephone Number		Occupation	

Days Child Care Is Needed
<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday
<p>What time of day should the Our Beginning staff expect your child to arrive and depart? This is essential in assigning adequate staff to care for your child.</p> <p>Monday</p> <p>Tuesday</p> <p>Wednesday</p> <p>Thursday</p> <p>Friday</p>

OTHER PEOPLE TO NOTIFY IN CASE OF EMERGENCY

Name	Address	10-Digit Telephone Number	
Relationship:		Work: Home:	Cell:
Relationship:		Work: Home:	Cell:
Relationship:		Work: Home:	Cell:
Relationship:		Work: Home:	Cell:

OTHER THAN YOURSELF, WHO HAS PERMISSION TO PICK UP THIS CHILD? (must be 18 years of age or older)

Name	Address	10-Digit Telephone Number	
		Work: Home:	Cell:
		Work: Home:	Cell:
		Work: Home:	Cell:

WHO DOES NOT HAVE PERMISSION TO PICK UP YOUR CHILD?

Name	Reason

CHILD'S HEALTH INFORMATION

Date of Child's Last Physical Examination:	Child's Health Care Provider's Name	10-Digit Telephone Number	
Street Address		City, State	Zip Code
Special Health Problems		Allergies, Including Drug Reactions	
Special Diet		Mobility Limitations	

CHILD'S HEALTH INFORMATION (continued)		
Regular Medications	Other Pertinent Data	
Child's Dentist's Name	10-Digit Telephone Number	
Street Address	City, State	Zip Code

CHILD'S MEDICAL INSURANCE COVERAGE	
Insurance Company Name	Member/Policy Number
Policy Holder Name	Employer Name
Insurance Company Name	Member/Policy Number
Policy Holder Name	Employer Name

CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR CHILDREN			
<p>I hereby give permission that my child, _____,</p> <p>may be given emergency treatment by a qualified child care provider at</p> <p>_____.</p> <p style="text-align: center;">Name and/or Address</p> <p>When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid-car attendant when deemed necessary or advisable by the physician or aid-car attendant to safeguard my child's health. I waive my right of informed consent to such treatment.</p> <p>I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.</p> <p>I certify (or declare) under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.</p>			
Parent/Guardian Signature	Date	Parent/Guardian Signature	Date
Parent/Guardian Signature	Date	Parent/Guardian Signature	Date