

# Child Information Form

Child's Name: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Child's Address: \_\_\_\_\_  
Street City/Town Zip Code

Place of Birth: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Schedule: MON \_\_\_\_\_ TUE \_\_\_\_\_ WED \_\_\_\_\_ THU \_\_\_\_\_ FRI \_\_\_\_\_

## Parent/Guardian Information

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Home E-mail Address: \_\_\_\_\_ Home E-mail Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Others in Family Relationship: \_\_\_\_\_

## Parent/Guardian Business Information

Company Name: \_\_\_\_\_ Company Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

## Medical Information

Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Race: \_\_\_\_\_ Gender ☐ M ☐ F

Identified Allergies: \_\_\_\_\_

Identifying Marks: \_\_\_\_\_

Health Insurance Provider: \_\_\_\_\_

## Physician/Dentist Information

Name of Physician/Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Address: \_\_\_\_\_  
Street City/Town Zip Code

Date of Child's Last Physical (WA State Only): \_\_\_\_\_

Name of Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist Address: \_\_\_\_\_  
Street City/Town Zip Code

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR CENTER USE:** Center: \_\_\_\_\_ Date of Admission \_\_\_\_\_ Age of Admission: \_\_\_\_\_

Date Registration Fee Rec'd: \_\_\_\_\_ Director's Initials: \_\_\_\_\_