Stepping Stones
EARLY LEARNING CENTER

Registration Form

Child's Name: _____ Birth date: _____ Age: _____
Address: _____ Zip: _____ Phone: _____
Mother's Name: _____ Phone: _____ Mobile: _____
Home Address: _____ Zip: _____
Mother's Workplace or School: _____ Phone: _____
Mother's Email Address: _____
Father's Name: _____ Phone: _____ Mobile: _____
Home Address: _____ Zip: _____
Father's Workplace or School: _____ Phone: _____
Father's Email Address: _____

Emergency Information

Name of Child's Health Care Facility: _____
Doctor: _____ File#: _____ Phone: _____
Medical Insurance Provider: _____
Medical Card Number: _____
Name of Dentist: _____ Phone: _____

PLEASE LIST TWO PERSONS WHO ARE WILLING AND ABLE TO ASSUME RESPONSIBILITY FOR YOUR CHILD IN CASE A PARENT CANNOT BE CONTACTED:

Name: _____ Relationship to Child: _____
Address: _____ Phone: _____

Name: _____ Relationship to Child: _____
Address: _____ Phone: _____

Is there anyone else not previously listed who is authorized to pick up your child?

Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____

***PLEASE NOTE: IF YOU NEED TO SEND AN ALTERNATE PERSON TO PICK UP YOUR CHILD, YOU MUST NOTIFY THE CENTER IN ADVANCE. WE WILL NOT RELEASE A CHILD TO ANY PERSON WITHOUT AUTHORIZATION FROM THE PARENT.**

Does your child take any medications on a regular or long term basis? _____
If yes, please list the medications: _____
How often is medication taken: _____
Is your child allergic to anything? _____ If yes, list allergies: _____
How should allergies be treated? _____

Name _____ Signature: _____ Date: _____