Child's Enrollment/Information Form

CHILD'S NAME: _____ PREFERRED NAME: _____

DOB: _____ SEX: _____ DATE ENROLLED: _____

ADDRESS: _____ ZIP CODE: _____

MOTHER'S NAME: _____ FATHER'S NAME: _____

CUSTODIAL PARENT (CIRCLE ONE): MOTHER FATHER JOINT

HOME PHONE: _____ HOME PHONE: _____

EMPLOYMENT: _____ EMPLOYMENT: _____

WORK PHONE: _____ WORK PHONE: _____

SS# (optional): _____ SS# (optional): _____

PERSONS AUTHORIZED TO REMOVE CHILD (IDENTIFICATION REQUIRED)

1. _____
NAME RELATIONSHIP PHONE

2. _____
NAME RELATIONSHIP PHONE

ALTERNATE NUTRITION PLAN AGREEMENT

I understand and approve the use of the Alternate Nutrition Plan. I agree to provide the following meals and/or snacks to meet my child's nutritional and dietary needs.

Indicate Special Dietary Requirements: _____

_____

(Mark P for Parent Provides, or C for Center Provides)

_____	_____	_____	_____	_____	_____	_____
Breakfast	A.M. Snack	Noon Meal	P.M. Snack	Dinner Snack	Evening	Formula

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HILLSBOROUGH COUNTY ORDINANCE requires that parents must receive a copy of the "KNOW YOUR CHILD'S DAY CARE FACILITY BROCHURE/FDCH BROCHURE", and the parent's are notified in writing of the "DISCIPLINARY PRACTICES" used by the child care facility. The parent's or legal guardian's signature certifies receipt of the child care facility brochure/fdch brochure, discipline policies, agreement of the alternate nutrition plan, and that all the information on this form is complete and accurate.

_____
Signature of Parent or Legal Guardian

Distributed by the Hillsborough County Childcare Licensing Program

Medical Alert Information (i.e., allergies, medical and/or handicapping conditions): _____

_____

List any additional information which would be beneficial for the child care staff to know about your child: _____

_____

Preferred Physician: _____

Address: _____ Phone: _____

Preferred Hospital: _____

NOTE: Immunization Record should accompany child.

EMERGENCY CONTACT (OTHER THAN PARENTS):

1. _____
NAME RELATIONSHIP PHONE

2. _____
NAME RELATIONSHIP PHONE

With medical Release

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

If my child, _____, should become ill or
CHILD'S FULL NAME

Injured at, _____, I understand that the
NAME OF FACILITY

Facility will: (1) Contact me immediately and (2) Contact the person (s) I have designated if I cannot be reached.

Should the facility be unable to reach me and/or the person(s) designated, they are authorized to contact my child's physician and/or arrange for immediate medical treatment.

The physician and/or medical facility are authorized to administer emergency medical treatment necessary to ensure the health and safety of my child.

I will accept responsibility for payment of medical services rendered.

_____
SIGNATURE RELATIONSHIP DATE

(OPTIONAL)

Sworn to and subscribed before me this _____, day of _____, 20_____.

_____
Notary Public, State of Florida – At Large.

My Commission Expires: _____

_____ who is/are personally known to me

_____ who has/have produced identification: _____