

Parent Basic *fields marked with an* are required*

PRIMARY PARENT/GUARDIAN

Parent Last Name* _____
Parent First Name* _____
Date of Birth _____ Gender:* Male Female
Race* Native American or Alaskan Native Asian White
 African American Native Hawaiian/Other Pacific Islander
Ethnicity* Hispanic/Latino Not Hispanic/Latino
Address Line 1* _____
Address Line 2 _____
City* _____
State* _____ Zip* _____
Primary Phone* _____
Secondary Phone _____
Work Phone _____
Email* _____
Start Date* _____
Relationship to the Child* _____
 Emergency Contact Authorized to Pickup
Instructions for Reaching Contact* _____

EMPLOYMENT

Unemployed
Occupation* _____
Employer Name* _____
Employer Address 1* _____
Employer Address 2 _____
City* _____
State* _____ Zip* _____
Main Phone* _____

ADDITIONAL INFORMATION

Where Do You Need Child Care?

When Do You Need Child Care?

Media Release

Child's Name _____

SECONDARY PARENT/GUARDIAN

Parent Last Name* _____
Parent First Name* _____
Date of Birth _____ Gender:* Male Female
Race* Native American or Alaskan Native Asian White
 African American Native Hawaiian/Other Pacific Islander
Ethnicity* Hispanic/Latino Not Hispanic/Latino
 Address same as Primary Parent
Address Line 1* _____
Address Line 2 _____
City* _____
State* _____ Zip* _____
Primary Phone* _____
Secondary Phone _____
Work Phone _____
Email* _____
Relationship to the Child* _____
 Emergency Contact Authorized to Pickup
Instructions for Reaching Contact* _____

EMPLOYMENT

Unemployed
Occupation* _____
Employer Name* _____
Employer Address 1* _____
Employer Address 2 _____
City* _____
State* _____ Zip* _____
Main Phone* _____



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Child Basic fields marked with an* are required

CHILD MAIN

Child Last Name* _____

Child Middle Name* _____

Child First Name* _____

Date of Birth* _____

Gender* Male Female

Race* Native American or Alaskan Native

Asian

White

African American

Native Hawaiian/Other Pacific Islander

Ethnicity* Hispanic/Latino Not Hispanic/Latino

Date of Enrollment* _____

Full-time Part-time

Emergency Medical Authorization Completion Date* _____

Emergency Medical Authorization Expiration Date* _____

I hereby give my consent to _____,
to call a doctor or emergency medical or surgical care for my child,

Parent/Guardian Signature

Date

Child's Name _____

MEDICAL INFORMATION

Allergies* Yes No

Allergy List _____

Medical Conditions* Yes No

Medical Conditions List _____

Medications* Yes No

Approved Medications List _____

Insurance Provider* _____

Insurance #* _____

HOSPITAL

Preferred Hospital* _____

Address 1* _____

Address 2 _____

City* _____

State* _____ Zip* _____

Hospital Phone* _____

AUTHORIZATIONS

Cot Permission (children 1-2 yrs only)

Sunscreen

TV/Video

Field Trip

Transportation

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* Emergency/Authorized Cont'd

fields marked with an* are required

CHILD EMERGENCY/AUTHORIZED TO PICKUP #4

Last Name* _____

First Name* _____

Relationship to the Child* _____

Emergency Contact Auth. to Pickup DOB _____

Address Line 1* _____

Address Line 2 _____

City* _____

State* _____ Zip* _____

Primary Phone* _____

Secondary Phone _____

Instructions for Reaching Contact* _____

CHILD EMERGENCY/AUTHORIZED TO PICKUP #5

Last Name* _____

First Name* _____

Relationship to the Child* _____

Emergency Contact Auth. to Pickup DOB _____

Address Line 1* _____

Address Line 2 _____

City* _____

State* _____ Zip* _____

Primary Phone* _____

Secondary Phone _____

Instructions for Reaching Contact* _____

Child's Name _____

CHILD EMERGENCY/AUTHORIZED TO PICKUP #6

Last Name* _____

First Name* _____

Relationship to the Child* _____

Emergency Contact Auth. to Pickup DOB _____

Address Line 1* _____

Address Line 2 _____

City* _____

State* _____ Zip* _____

Primary Phone* _____

Secondary Phone _____

Instructions for Reaching Contact* _____

CHILD EMERGENCY/AUTHORIZED TO PICKUP #7

Last Name* _____

First Name* _____

Relationship to the Child* _____

Emergency Contact Auth. to Pickup DOB _____

Address Line 1* _____

Address Line 2 _____

City* _____

State* _____ Zip* _____

Primary Phone* _____

Secondary Phone _____

Instructions for Reaching Contact* _____

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*** Child Schedule** *fields marked with an* are required*

Start Date* _____

FULL & HALF DAY OR MORNING SCHEDULE*

	<i>Drop-Off</i>	<i>Pick-Up</i>
Monday	_____	_____
Tuesday	_____	_____
Wednesday	_____	_____
Thursday	_____	_____
Friday	_____	_____
Saturday	_____	_____
Sunday	_____	_____

AFTERNOON SCHEDULE

	<i>Drop-Off</i>	<i>Pick-Up</i>
Monday	_____	_____
Tuesday	_____	_____
Wednesday	_____	_____
Thursday	_____	_____
Friday	_____	_____
Saturday	_____	_____
Sunday	_____	_____

CHILD EMERGENCY/AUTHORIZED TO PICKUP #1

Last Name* _____

First Name* _____

Relationship to the Child* _____

Emergency Contact Auth. to Pickup DOB _____

Address Line 1* _____

Address Line 2 _____

City* _____

State* _____ Zip* _____

Primary Phone* _____

Secondary Phone _____

Instructions for Reaching Contact* _____

Child's Name _____

CHILD EMERGENCY/AUTHORIZED TO PICKUP #2

Last Name* _____

First Name* _____

Relationship to the Child* _____

Emergency Contact Auth. to Pickup DOB _____

Address Line 1* _____

Address Line 2 _____

City* _____

State* _____ Zip* _____

Primary Phone* _____

Secondary Phone _____

Instructions for Reaching Contact* _____

CHILD EMERGENCY/AUTHORIZED TO PICKUP #3

Last Name* _____

First Name* _____

Relationship to the Child* _____

Emergency Contact Auth. to Pickup DOB _____

Address Line 1* _____

Address Line 2 _____

City* _____

State* _____ Zip* _____

Primary Phone* _____

Secondary Phone _____

Instructions for Reaching Contact* _____

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Tell Us About Your Child, Cont'd

Child's Name _____

CHILD'S DEVELOPMENT

At what age did your child speak words? _____ Walk? _____

Does your child need reminding about going to the bathroom?

Yes No

Does your child nap? Yes No

Time Frame? _____ Duration? _____

CHILD'S EXPERIENCES

What language(s) are spoken in your home?

What other care & education environment has your child experienced (nanny, grandparents, child care, school, etc)?

What tends to be your child's temperament at home?

Very Easy Going Fairly Easy Fairly Difficult

How does your child interact with other children?

Is there anything else we should know to prepare for your child?

I acknowledge that I have received and will abide by the policies and procedures in the Family Handbook.

Parent/Guardian Signature

Current Date

Center/Home Provider Signature

Current Date



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18 Inverness Place East • Englewood, CO 80112

Phone: 303.789.2664 • Fax: 303.789.2696

help@earlylearningventures.org

www.EarlyLearningVentures.org

* Doctor & Dentist Information

fields marked with an* are required

DOCTOR*

Doctor Last Name* _____

Doctor First Name* _____

Agency* (Office/Hospital Name) _____

Address Line 1* _____

Address Line 2 _____

City* _____

State* _____ Zip* _____

Phone* _____

Email _____

Date of Last Visit* _____

Child's Name _____

DENTIST*

Dentist Last Name* _____

Dentist First Name* _____

Agency* (Office/Hospital Name) _____

Address Line 1* _____

Address Line 2 _____

City* _____

State* _____ Zip* _____

Phone* _____

Email _____

Date of Last Visit* _____

* Tell Us About Your Child

Foods to avoid due to parent preference:
(NOT food allergies, strictly preference in this space. Allergies addressed on p2)

What are your child's favorite play activities?

How does your child relax or calm him/herself down?

How does your child fall asleep?

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