

OPEN ARMS CHRISTIAN EARLY CHILDHOOD CENTER REGISTRATION & EMERGENCY INFORMATION FORM

Child's Name: _____ Birth Date: _____
 Last First Middle Sex: _____
Address: _____ Telephone: _____
City: _____ State: _____ Zip: _____
Family's Church: _____ Child's Baptism Date: _____

Parent(s)/Guardian(s) Information

Mother's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Employed by: _____
Business Address: _____
City: _____ State: _____ Zip: _____
Home: _____ Cell: _____ Work: _____
Email Address: _____

Father's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Employed by: _____
Business Address: _____
City: _____ State: _____ Zip: _____
Home: _____ Cell: _____ Work: _____
Email Address: _____

Emergency Contact Information/People Authorized to Transport Child

Name of Contact #1: _____
Relationship to Child: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home: _____ Cell: _____ Work: _____

Name of Contact #2: _____
Relationship to Child: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home: _____ Cell: _____ Work: _____

Name of Contact #3: _____
Relationship to Child: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home: _____ Cell: _____ Work: _____

Please complete both sides

Medical Information:

Allergies to Food and/or Drugs:

Medical Conditions:

Physicians Name: _____ Telephone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Dentist Name: _____ Telephone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Medical Insurance

Company: _____ Policy Number: _____

Preferred Hospital: _____

Parent
Initials

_____ I give permission for the staff at Open Arms to consult with the Poison Control Center in the event of accidental ingestion.

_____ I give permission to Open Arms to make whatever emergency measures (i.e. first aid, disaster evacuation) are judged necessary for the care and protection of my child while under the supervision of the Center.

_____ In case of a medical emergency, I understand that my child will be transported to an appropriate medical facility by local medical response units for treatment if the Emergency Response Unit deems it necessary. The child will be transported at the expense of the medical insurer and/or parents.

_____ It is understood that in some medical emergency situations, the staff of Open Arms will need to contact the local Emergency Response Units before the parent/s, child's physician, and/or the emergency contacts listed on this form.

Mother's Signature

Date

Father's Signature

Date