Child Care Registration Form

Date child entered care	Date child left care

Child's name Last First Middle	Name (Nickname) used	Birthdate

Street address	City	Zip code

Child's parent/guardian name	home phone # ( ) -	cell phone# ( ) -	alternative phone # ( ) -

Street address	City	Zip code

Address where you can be reached while child is in care	City	Zip code

Child's parent/guardian name	home phone # ( ) -	cell phone# ( ) -	alternative phone # ( ) -

Street address	City	Zip code

Address where you can be reached while child is in care	City	Zip code

Other than you, who else has permission to pick up your child?

Name	Address	Telephone number
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -

In case of an emergency, I give permission for any of the following individuals to be contacted and my child may be released to any of them.

Parent/Guardian signature: _____

Name	Address	Telephone number
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -
Name: Relationship:		Home: ( ) - Cell: ( ) - Alternative: ( ) -

Who does not have permission to pick up your child? If applicable (A copy of supporting court document must be on file)	
Name	Reason

Child's health information		
Date of child's last physical exam:	Child's health care provider	Telephone number ( ) -
Street address	City	Zip code

Special health problems? Yes or no? If yes, specify.	Allergies, including drug reactions Yes or no? If yes, specify.
Regular medications? Yes or no? If yes, specify.	Other important information Yes or no? If yes, specify.
Child's dentist's name	Telephone number ( ) -
Street address	City Zip code

Child's medical insurance coverage	
Insurance company name	Member/policy number
Policy holder name	Employer name
Insurance company name	Member/policy number
Policy holder name	Employer name

Consent to medical care and treatment of minor children

I give permission that my child,_____, may be given first aid/emergency treatment by a the child care licensee and/or qualified staff at:

Name of Licensee_____,

Address of Licensee_____.

Parent/guardian signature	Date	Parent/guardian signature	Date

When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health. I waive my right of informed consent to such treatment.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.

Parent/guardian signature	Date	Parent/guardian signature	Date

Child Care Agreement

Child's name:	First	Middle	Last
Parent or guardian name:	First	Middle	Last
Parent or guardian name:	First	Middle	Last

Days and times my child will receive care:

Check days of care	☐ Sunday	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ Saturday
Arrival time							
Departure time							

Fee: $ per:

☐ Hour ☐ Day ☐ Week ☐ Month

Date payment due:

Source of payment: ☐ Parent ☐ Other (specify):

Overtime rate: $ per

Late fee: $ per

Other Fees: $ Description:

I agree to promptly notify the child care provider of any changes of the above information. I understand that I am fully responsible for the terms of this agreement as stipulated.

I have read, understand and agree to comply with the policy and procedures and information for parents given to me by

_____

Name of licensee

Parent or guardian signature	Date	Parent or guardian signature	Date

I agree to provide child care services according to the above plan. I agree to promptly notify the parents or guardians of any changes to above information.

Licensee signature			Date
Street address	City	State	Zip code

Comments

Family Home Child Care
General Permission Authorization

WAC 170-296A-6400 Off-site activities—Parent or guardian permission

(2) For scheduled or unscheduled off-site activities that may occur more than once a month, the licensee must:
(a) Have a signed parent or guardian permission on file for each child; and
(b) Inform parents and guardians about how to contact the licensee when children are on an off-site activity

Child's name First Middle Last	Licensee's Name

Off-site activities that may occur more than once a month:
☐ Walks
☐ Neighborhood Park
☐ Other (specify)
☐ Other (specify)

The children will be transported by motor vehicle: Yes ☐ No ☐	We will be going on this outing using public transportation: Yes ☐ No ☐

Notes:

I give permission for my child to participate in the off-site activities checked above:

Child's name:

Parent or guardian signature	Date

This permission is granted when the licensee follows all the requirements for transporting children. WAC 170-296A-6475

In case of an emergency, I give permission for my child to receive medical treatment. In case of such an emergency, please contact:

Name	Phone Number ( ) -

Parent or guardian signature	Date

Copies to parent or guardian and licensee

Certificate of Immunization Status (CIS)

Washington State Department of Health

Reviewed by:	Date:
Signed COE on File? ☐ Yes ☐ No	

Please print. See back for instructions on how to fill out this form or get it printed from the Washington State Immunization Information System.

Child's Last Name:	**First Name:**	**Middle Initial:**	**Birthdate (MM/DD/YYYY):**

I give permission to my child's school/child care to add immunization information into the Immunization Information System to help the school maintain my child's record.	Conditional Status Only: I acknowledge that my child is entering school/child care in conditional status. For my child to remain in school, I must provide required documentation of immunization by established deadlines. See back for guidance on conditional status.
X _____ **Parent/Guardian Signature** **Date**	X _____ **Parent/Guardian Signature Required if Starting in Conditional Status** **Date**

▲Required for School • Required Child Care/Preschool	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
Required Vaccines for School or Child Care Entry						
•▲ DTaP (Diphtheria, Tetanus, Pertussis)						
▲ Tdap (Tetanus, Diphtheria, Pertussis) (grade 7+)						
•▲ DT or Td (Tetanus, Diphtheria)						
•▲ Hepatitis B						
• Hib (*Haemophilus influenzae type b*)						
•▲ IPV (Polio) (any combination of IPV/OPV)						
•▲ OPV (Polio)						
•▲ MMR (Measles, Mumps, Rubella)						
• PCV/PPSV (Pneumococcal)						
•▲ Varicella (Chickenpox) ☐ History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV/MPSV (Meningococcal Disease types A, C, W, Y)						
MenB (Meningococcal Disease type B)						
Rotavirus						

Documentation of Disease Immunity (Health care provider use only)

If the child named in this CIS has a history of varicella (chickenpox) disease or can show immunity by blood test (titer), it must be verified by a health care provider.

I certify that the child named on this CIS has:
☐ A verified history of varicella (chickenpox) disease.
☐ Laboratory evidence of immunity (titer) to disease(s) marked below.

☐ Diphtheria	☐ Hepatitis A	☐ Hepatitis B
☐ Hib	☐ Measles	☐ Mumps
☐ Rubella	☐ Tetanus	☐ Varicella

☐Polio (all 3 serotypes must show immunity)

▶

Licensed Health Care Provider Signature Date

▶

Printed Name

I certify that the information provided on this form is correct and verifiable.

Health Care Provider or School Official Name: _____ Signature: _____ Date:_____
If verified by school or child care staff the medical immunization records must be attached to this document.