***Shining Stars Preschool Registration Form***

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| Registration Form | Date Student Starts: | | | Date Student Leaves: |
| Students name: Last First Middle | | | | Birth date: |
| Street Address City Zip code | | | | |
| Student’s Parent/Guardians Name | | Home/cell phone # | | Work phone # |
| Street Address City Zip code | | | | |
| Student’s Parent/Guardians Name | | Home/cell phone # | | Work phone # |
| Street Address 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 documents must be on file) | | | | |
| Name | Reason | | | |
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| 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 Medication:  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 the licensee and/or qualified staff at:  Name of Licensee: Shannon L McComb  Address of Licensee: 16617 N Cincinnati Ct. Spokane, WA 99208 | | | | |
| 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. | | | | |