



CHILD ENROLLMENT

Child's Name	(Nickname)	Date of Birth	Sex
Home Address		Home Phone	
PARENT/GUARDIANS			
Parent/Guardian	Relationship to Child	Cell Phone	Email
Home Address	Employer	Business Phone	Social Sec #
Parent/Guardian	Relationship to Child	Cell Phone	Email
Home Address	Employer	Business Phone	Social Sec #
Family Doctor		Contact information	



EMERGENCY CONTACTS

Emergency Contact #1		
NAME		RELATIONSHIP TO CHILD
HOME PHONE	CELL PHONE	WORK PHONE
HOME ADDRESS		

Emergency Contact #2		
NAME		RELATIONSHIP TO CHILD
HOME PHONE	CELL PHONE	WORK PHONE
HOME ADDRESS		

Emergency Contact #3		
NAME		RELATIONSHIP TO CHILD
HOME PHONE	CELL PHONE	WORK PHONE
HOME ADDRESS		
Persons NOT Authorized to Pick up child:		



Child's Name _____ **Classroom** _____

For Infant-Preschool Developmental History:

Age child began sitting: _____ Crawling: _____ Walking: _____ Talking _____

Is your child a good climber? ___Yes ___No Does he/she fall easily? ___Yes ___No

Primary speaking language: _____

Any speech difficulties? ___Yes ___No

List any major illnesses or physical conditions past or present: _____

List any accidents, operations or hospitalizations: _____

Is your child presently under a physician's care? ___Yes ___No If yes, Dr.'s Name: _____

Is your child presently taking any medication? ___Yes ___No

If yes, describe side effects: _____

Does your child use any special devices at home? ___Yes ___No If yes, what kind? _____

Sleeping:

Does your child go to sleep easily? ___Yes ___No

Does your child have any disturbances while sleeping? ___Yes ___No Please Describe: _____

Does your child usually take naps? ___Yes ___No From when to when? _____

Do you have any concerns about your child's sleeping habits? _____

Eating:

Describe your child's appetite: _____

Does your child feed him/herself? ___Yes ___No ___ With a spoon ___ With a fork ___ With hands

What are his/her favorite foods? _____

What foods has he/she refused? _____

What are his/her usual eating hours: _____ Breakfast _____ Lunch _____ Dinner

Do you have any concerns about your child's eating habits? _____

Safe sleeping for Infants:



At First Steps Early Learning Center we follow the recommendations made by the American Academy of Pediatrics. Infants who cannot turn over will be placed on their backs to sleep.

Medical Information

Allergies or Intolerance _____

Treatment _____

Last Tetanus/diphtheria booster _____

Current Medications _____

Child's Physician _____ Phone _____

Office Name _____

Address _____

City _____ State _____ Zip Code _____

Hospital Name _____ Phone _____

Address _____

City _____ State _____ Zip Code _____

Dentist Name _____ Phone _____

Address _____

City _____ State _____ Zip Code _____

Health Insurance

Insurance Company _____ Phone _____

Policy Number _____

Office Name _____

Address _____

City _____ State _____ Zip Code _____



AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR

I authorize the staff of First Steps Early Learning Center to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of the center's Pediatric Group or Surgeon licensed to practice in the State of New Jersey, when the need for such treatment is immediate, and when efforts to contact me are unsuccessful.

Child's Name _____

Address _____

Home Phone Number _____

Parent/Guardian _____ Relationship to Child _____

Work Number _____ Cell Phone Number _____

Parent/Guardian _____ Relationship to Child _____

Work Number _____ Cell Phone Number _____

Child's Date of Birth _____

Allergies _____

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

Witness/Director

Date



AUTHORIZATION FOR EMERGENCY RELEASE OF A MINOR

I authorize the staff of First Steps Early Learning Center to release the minor in the event of an emergency evacuation when the need for such action is immediate and when efforts to contact me are unsuccessful.

Child's Name _____

Address _____

Home Phone Number _____

Parent/Guardian _____ Relationship to Child _____

Work Number _____ Cell Phone Number _____

Parent/Guardian _____ Relationship to Child _____

Work Number _____ Cell Phone Number _____

Child's Date of Birth _____

Allergies _____

Additional Emergency Contact Persons:

Name _____ Phone Number _____

Name _____ Phone Number _____

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

Witness/Director

Date



Child's Name _____

Medication and Prescription # _____

Amount of Medication _____

Dates of Medication _____

Times to administer _____

DATE	TIME	AMOUNT GIVEN	SIGNATURE

Reactions indicating medication should be discontinued (call parent immediately):

I release First Steps Early Learning Center employees from any claims and liability for administering of medication.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

Witness/Director

Date

WAIVER FORM



I, _____ (Parent/Guardian), have hereby agreed to enroll my child into the First Steps Early Learning Center program. I have received the information which explains the activities in which my child will become involved at the center and consent to his/her involvement.

In exchange for the participation of my child in the activities of the Center, I agree to the following:

1. To observe and obey all posted rules and warnings, and further to follow any oral instructions or directions given by the employees or director of the Center.
2. I recognize that there are certain inherent risks associated with the activities at the center. I agree to instruct my child in an age appropriate fashion to follow all rules at the Center.
3. I acknowledge that my child is assuming the inherent risk of injury for certain activities which are conducted at the Center.
4. In consideration of your enrollment at the Center and access to the child care programs and facility of the center, the Parent/Guardian hereby agrees to release, absolve, indemnify and hold harmless the Center, its staff, employees and other representatives (collectively the "released parties") from any and all claims, liabilities or lawsuits for any bodily injury suffered by him/her, including death, or for any other consequential or incidental damages caused in any manner whatsoever where any such claim, liability or lawsuit is not attributable to ordinary negligence or absence of ordinary care of the released parties.
5. The Parent/Guardian expressly waives any claims arising from the above that may be brought at any time by the Parent/Guardian, his/her family, estate heirs or assigns, and assumes all risk and hazards attendant to the use of the facilities, use of equipment, or participation in program events or instructional classes.

I HAVE CAREFULLY READ THE GENERAL LIABILITY RELEASE AND WAIVER OF CLAIMS FOR AND FULLY UNDERSTAND ITS CONTENTS. I UNDERSTAND THIS DOCUMENT AND THIS I AM WAIVING MY RIGHT TO MAKE CLAIMS AGAINST THE RELEASED PARTIES. I AM AWARE THAT THIS RELEASE OF LIABILITY AND A CONTRACT BETWEEN MYSELF, ON BEHALF OF MY CHILD, AND THE CENTER AND SIGN IT VOLUNTARILY AND OF MY OWN FREE WILL.

Parent/Guardian

Date

Parent/Guardian

Date