Enrollment Form 2024

Child's Name: _____

Date of Enrollment: _____

Home Address: _____

_____

Home Phone: _____ Sex: M F Age: _____

Date of Birth: _____

Family Members:

Mother or Guardian's Name: _____

Address if different from child's: _____

Zip: _____ Home Phone: _____ Cell Phone: _____

Email: _____

Name of Employment (Mother/Guardian):

_____

Address of Employment: _____Work Phone: _____

Father or Guardian's Name:

_____

Address if different from child's:

_____

Zip: _____ Home Phone: _____ Cell Phone: _____

Email: _____

Name of Employment (Father/Guardian):

_____

Address of Employment: _____ Work Phone: _____

Special instructions for reaching parent or guardian:

_____

Emergency Contacts:

1.Name: _____

Contact number: _____

Address: _____

Work Phone: _____ Relationship to child: _____

2. Name: _____

Contact number: _____

Address: _____

Work Phone: _____Relationship to child: _____

Child Pickup Information

Persons Authorized to pick up your child (Must show photo ID)

Name: _____

Home Phone: _____ Work Phone: _____

Name: _____

Home Phone: _____ Work Phone: _____

Name: _____

Home Phone: _____ Work Phone: _____

Name, address and phone number of child's doctor:

_____

_____

Name, address and phone number of child's dentist:

_____

_____

Hospital of Preference (Please check one):

☐ UC Health Memorial Central
1400 E Boulder St.
Colorado Springs 80909
719-365-500

☐ Common Spirit Penrose Hospital
2222 N Nevada Avenue
Colorado Springs, CO 80907
719-776-5000

☐ Other _____

Chronic Medical Conditions: _____

Does your child have a health care plan? _____

If yes, the health care plan must be provided on or before the first day the child is in care.

Is your child fully immunized? _____

Complete immunization records must be provided on or before the first day the child is in care.

Food Allergies:

_____

Health History

Allergies

(Chronic or Recurring) (Nature of Reaction)

Ear Infections: _____ Hay Fever: _____

Diabetes: _____ Plant Poisoning: _____

Heart disease/defect: _____ Insect Stings: _____

Convulsions/seizures: _____ Penicillin: _____

Asthma: _____ Other drugs: _____

Nosebleeds: _____ Animals: _____

Measles: _____ Food: _____

Mumps: _____ Other: _____

Chicken Pox: _____

Flu or Flu Shot: _____

Operations or serious injuries (dates):_____

Is the child on any medications? (Explain)_____

If yes, please describe: _____

Physical Limitations: _____ Describe if yes:

_____

Dietary Limitations: _____ Describe if yes:

_____

Vision: _____ Hearing: _____

Are there any activities that you prefer that your child NOT participate in?

If so, please list: _____

I hereby give permission for SmartStart Academy to call a doctor or emergency medical services and for the doctor, hospital, or medical service to provide emergency medical or surgical care for my child,

_____.

It is understood that the childcare provider will make a conscientious effort to locate the parent/guardians and emergency contacts listed on the registration document before any action is taken. If it is not possible to locate the emergency contacts that are listed, treatment will not be delayed. I/we will accept the expense of any emergency transportation, medical or surgical treatment.

Parent/Guardian Signatures:

_____ Date: _____

_____ Date: _____

Annual Updates

Parent/Guardian Signatures:

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____