Blossom Learning Center 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: ( ) -
Name: Relationship:		Home: ( ) -Cell: ( ) -
Name: Relationship:		Home: ( ) -Cell: ( ) -
Name: Relationship:		Home: ( ) -Cell: ( ) -

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