FIRST STEPS
CHILDCARE & PRESCHOOL

Enrollment Form

Child's Name: _____ Gender: M ☐ F ☐ Birth Date: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Change of Address if needed: _____

Parent's Name: _____ Email: _____

Employer: _____ Cell Phone: _____ Work Phone: _____

Parent's Name: _____ Email: _____

Employer: _____ Cell Phone: _____ Work Phone: _____

Emergency Contacts (other than parents) and Persons Authorized to Pick-Up the Child

Name	Relationship to Child	Address	Phone
Out of Area/State (if available)	Relationship to Child	Address	Phone

In the case of serious injury or illness, it is First Steps' policy to notify a parent or emergency contact of the need for medical attention. If the child's life is in danger and needs immediate help, First Steps' procedure is to arrange for the child to be taken to the nearest emergency facility by ambulance before contacting parents.

I hereby authorize the staff at First Steps Childcare to obtain emergency medical care and/or provide emergency transportation for my child.

Signature of Parent/Guardian: _____ **Date:** _____

**This form must be completed for each individual child enrolled, and must be reviewed annually by the parent/guardian, and any changes noted.*

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Child Health Assessment

Name of Child: _____ *Birth Date:* _____

Does your child have any known allergies or sensitivities to any of the following?

Type	Yes/No	If Yes, please explain:
Medications	Yes ☐ No ☐	
Foods	Yes ☐ No ☐	
Other	Yes ☐ No ☐	

Does your child have any of the following Illnesses or Medical Conditions?

Type	Yes/No	If Yes, please explain:
Asthma	Yes ☐ No ☐	
Diabetes	Yes ☐ No ☐	
Seizures	Yes ☐ No ☐	
Heart Problems	Yes ☐ No ☐	
Hearing Impairment	Yes ☐ No ☐	
Visual Impairment	Yes ☐ No ☐	
Development Delays	Yes ☐ No ☐	
Physical Impairment	Yes ☐ No ☐	
Emotional Problems	Yes ☐ No ☐	
Other	Yes ☐ No ☐	

Please list any additional health information or special instructions you may feel we need to be aware of:

Please list any regular medications your child takes:

Name of child's Medical Provider: _____ *Phone:* _____

Date of last exam: _____ *Immunizations up to date? Yes* ☐ *No* ☐

Parent/Guardian Signature: _____ *Date:* _____

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