



# Grandma's House Registration Form

(for drop-off child care)

Please print neatly!

**Today's Date:** \_\_\_\_\_

**PRIMARY GUARDIAN** Circle Relationship: Parent Grandparent Step-Parent Foster-Parent Relative A friend

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ State \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Children's Doctor Name / Phone \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Children's Dentist Name / Phone \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

**EMERGENCY CONTACTS** Must list at least one contact other than parents as an Emergency Contact

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ State \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Circle Relationship: Parent Grandparent Step-Parent Foster-Parent Relative A friend Emergency Contact? Yes No

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ State \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Circle Relationship: Parent Grandparent Step-Parent Foster-Parent Relative A friend Emergency Contact? Yes No

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ State \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Circle Relationship: Parent Grandparent Step-Parent Foster-Parent Relative A friend Emergency Contact? Yes No

## CHILD INFORMATION

	CHILD #1	CHILD #2	CHILD #3
Name:	Name:	Name:	Name:
Birthdate:	Birthdate:	Birthdate:	Birthdate:
Sex:	M F	M F	M F
Dietary Restrictions			
1. Food Allergies?	Yes No	Yes No	Yes No
2. Other Dietary Restrictions?	Yes No	Yes No	Yes No
Medical			
3. Medicine Allergies?	Yes No	Yes No	Yes No
4. Insect Bite Allergies?	Yes No	Yes No	Yes No
5. Other Allergies?	Yes No	Yes No	Yes No
6. Take Medications?	Yes No	Yes No	Yes No
7. Asthma?	Yes No	Yes No	Yes No
8. Hearing/Vision Problems?	Yes No	Yes No	Yes No
9. Past Health Problems?	Yes No	Yes No	Yes No
Other Problems			
10. Activity Restrictions?	Yes No	Yes No	Yes No
11. Special Routines?	Yes No	Yes No	Yes No
12. Usually Take a Nap?	Yes No	Yes No	Yes No

Please explain any Yes answers, noting Child's name and question number: \_\_\_\_\_

**SIGNATURE REQUIRED** \_\_\_\_\_ **DATE:** \_\_\_\_\_