DEPARTMENT OF EARLY LEARNING (DEL)
FAMILY CHILD CARE HOME

CHILD CARE HOME REGISTER

DATE CHILD ENTERED CARE	DATE CHILD LEF CARE

CHILD'S NAME LAST	FIRST	MIDDLE	NAME USED	BIRTHDATE

STREET ADDRESS	CITY	ZIP CODE

CHILD'S PARENT/GUARDIAN'S NAME	HOME TELEPHONE NUMBER (AND AREA CODE)	WORK TELPHONE NUMBER (AND AREA CODE)

STREET ADDRESS	CITY	ZIP CODE

WORK ADDRESS (OR WHERE YOU CAN BE REACHED WHILD CHILD IS IN CARE)	CITY	ZIP CODE

CHILD'S PARENT/GUARDIAN'S NAME	HOME TELEPHONE NUMBER (AND AREA CODE)	WORK TELPHONE NUMBER (AND AREA CODE)

STREET ADDRESS	CITY	ZIP CODE

WORK ADDRESS (OR WHERE YOU CAN BE REACHED WHILD CHILD IS IN CARE)	CITY	ZIP CODE

OTHER PEOPLE TO NOTIFY IN CASE OF EMERGENCY

NAME	ADDRESS	TELEPHONE NUMBER
Relationship:		Work: Home:
Relationship:		Work: Home:
Relationship:		Work: Home:
Relationship:		Work: Home:

OTHER THAN YOU, WHO HAS PERMISSION TO PICK UP YOUR CHILD?

NAME	ADDRESS	TELEPHONE NUMBER
		Work: Home:
		Work: Home:
		Work: Home:

WHO DOES NOT HAVE PERMISSION TO PICK UP YOUR CHILD?

NAME	REASON

CHILD'S HEALTH INFORMATION

DATE OF CHILD'S LAST PHYSICAL EXAMINATION:	CHILD'S HEALTH CARE PROVIDER'S NAME	TELEPHONE NUMBER (AND AREA CODE)
STREET ADDRESS	CITY	ZIP CODE

SPECIAL HEALTH PROBLEMS	ALLEGIES, INCLUDING DRUG REACTIONS
REGULAR MEDICATIONS	OTHER PERTINENT DATA

CHILD'S DENTIST'S NAME	TELEPHONE NUMBER (AND AREA CODE)
STREET ADDRESS	CITY ZIP CODE

CHILD'S MEDICAL INSURANCE COVERAGE

INSURANCE COMPANY'S NAME	MEMBER/POLICY NUMBER
POLICY HOLDER'S NAME	EMPLOYER'S NAME

INSURANCE COMPANY'S NAME	MEMBER/POLICY NUMBER
POLICY HOLDER'S NAME	EMPLOYER'S NAME

CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR CHILDREN

I hereby give permission that my child, _____,

may be given emergency treatment by a qualified child care provider at

Michelle Sun 13935 122nd Ave. NE, Kirkland WA 98034,

NAME AND/OR ADDRESS

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 (or declare) under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

PARENT/GUARDIAN'S SIGNATURE DATE	PARENT/GUARDIAN'S SIGNATURE DATE
STREET ADDRESS CITY ZIP CODE	TELEPHONE NUMBER (AND AREA CODE)