Child's Enrollment/Information Form

CHILD'S NAME: _____ PREFERRED NAME: _____

DOB: _____ DATE ENROLLED: _____

ADDRESS: _____ ZIP CODE: _____

MOTHER'S NAME: _____ FATHER'S NAME: _____

CUSTODIAL PARENT (CIRCLE ONE): MOTHER ☐ FATHER ☐ JOINT ☐

HOME/CELL PHONE: _____ HOME/CELL PHONE:_____

EMPLOYER: _____ EMPLOYER: _____

WORK PHONE: _____ WORK PHONE: _____

LEGAL GUARDIAN NAME (if different than above):_____

PERSONS AUTHORIZED TO REMOVE CHILD (LEGAL IDENTIFICATION REQUIRED)

1. _____
   NAME RELATIONSHIP PHONE

2. _____
   NAME RELATIONSHIP PHONE

ALTERNATE NUTRITION PLAN AGREEMENT

I understand and approve the use of the Alternate Nutrition Plan. I agree to provide the following meals and/or snacks to meet my child's nutritional and dietary needs.

Indicate any Special Dietary Requirements:

_____

_____

(Mark "P" for Parent Provides, or "C" for Center Provides)

_____	_____	_____	_____	_____	_____	_____
Breakfast	A.M. Snack	Noon Meal	P.M. Snack	Dinner	Evening Snack	Formula

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HILLSBOROUGH COUNTY ORDINANCE requires that parents must receive a copy of the "KNOW YOUR CHILD CARE FACILITY/FCCH BROCHURE", information on the INFLUENZA (FLU) VIRUS, information on "DISTRACTED DRIVER", and "RILYA WILSON ACT" and the parents are notified in writing of the "DISCIPLINARY PRACTICES" and "EXPULSION POLICY" used by the Child Care Facility/FCCH. The parent's/ legal guardian's signature certifies receipt of the Child Care Facility/FCCH brochure, influenza information, discipline policies, alternate nutrition plan agreement and that all the information on this form is complete and accurate.

_____ _____

Signature of Parent or Legal Guardian Date

Distributed by the Hillsborough County Childcare Licensing Program

Medical Alert Information (i.e., allergies, medical and/or special needs/conditions): _____

_____

List any additional information which would be beneficial for the child care provider to know about your child: _____

_____

Preferred Physician: _____

Address: _____ Phone: _____

Preferred Hospital: _____

NOTE: Physical & Immunization Record should accompany child.

EMERGENCY CONTACT (OTHER THAN PARENTS):

1. _____
NAME RELATIONSHIP PHONE

2. _____
NAME RELATIONSHIP PHONE

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

If my child, _____, should become ill or
CHILD'S FULL NAME

Injured at, _____, I understand that the
NAME OF FACILITY/PROVIDER

Child Care Provider will: (1) Contact me immediately and (2) Contact the person (s) I have designated if I cannot be reached.

Should the provider be unable to reach me and/or the person(s) designated, they are authorized to contact my child's physician and/or arrange for immediate medical treatment.

The physician and/or medical facility are authorized to administer emergency medical treatment necessary to ensure the health and safety of my child.

I will accept responsibility for payment of medical services rendered.

_____
SIGNATURE RELATIONSHIP DATE

(OPTIONAL)

Sworn to and subscribed before me this _____, day of _____, 20_____.

_____
Notary Public, State of Florida – At Large.

My Commission Expires: _____

_____ who is/are personally known to me

_____ who has/have produced identification: _____