

## VOLUNTARY REGISTRATION PROGRAM CHILDREN'S RECORD

**Full Name of Child:** \_\_\_\_\_ **Nickname:** \_\_\_\_\_

Address of Child: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Enrollment: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Withdrawal: \_\_\_\_/\_\_\_\_/\_\_\_\_

**\* Proof of Identity:**

Place of Birth	Birth Date	Birth Certificate Number	Date Issued
Other form of Proof	Birth Date	Date Documentation Viewed	Person Viewing Documentation

Previous Schools and Daycare attended: \_\_\_\_\_

Date of Notification of Local Law Enforcement Agency (when required proof of identity is not provided within 7 days of enrollment.) \_\_\_\_\_

**Parent/Guardian Information**

Mother's Name: \_\_\_\_\_

Mother's Address: \_\_\_\_\_

Mother's Home Phone Number: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_

Mother's Employer's Address: \_\_\_\_\_

Mother's Work Phone Number: \_\_\_\_\_ Work Hours: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Father's Address: \_\_\_\_\_

Father's Home Phone Number: \_\_\_\_\_

Father's Employer: \_\_\_\_\_

Father's Employer's Address: \_\_\_\_\_

Father's Work Phone Number: \_\_\_\_\_ Work Hours: \_\_\_\_\_

**CHILD'S MEDICAL INFORMATION**

Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_

**Hospitalization/Insurance Information:**

Name of Policy: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

List the child's known or suspected allergies or any chronic or recurrent diseases or disabilities (include any known drug allergies and if so, detailed directions for giving medicines to the child):

\* Proof of identity may be a certified copy of the child's birth certificate, birth registration card, notification of birth, passport, copy of placement agreement or other proof from a child-placing agency, record from a public school in Virginia, certification by a principal of a public school in the U.S. that a certified copy of the child's birth record was previously viewed. For additional information contact the contract agency.

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EMERGENCY CONTACT(S) - Persons to be called in case of emergency when a parent cannot be reached during the hours the child is in care.

1. Name: Address: Phone: 2. Name: Address: Phone:

Person's authorized to visit or call for child:

Person's Not Authorized to visit or call for child:

\*\*\*\*\*

I hereby authorize to take the actions initialed below:

Name of Provider

To use the following substitute provider(s):

Name of substitute provider: Address of substitute provider: Phone:

To transport my child and take trips out of the immediate community.

To obtain immediate care and, if necessary, the hospitalization of, the performance of necessary diagnostic tests upon, the use of surgery on, and/or the administration of drugs to, my child or ward if an emergency occurs when I cannot be located immediately. (Complete Child's Emergency Medical Authorization Form)

To give nonprescription medication only as directed by the instructions on the original container and with my written consent. (Authorization to give medication form must be completed.)

To give prescription medication only as directed by the authentic prescription label and with my written consent. (Provider or assistant must be MAT certified prior to administering prescription medication. Authorization to give medication form must be completed.)

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I agree to place in the care of between the hours of for days a week. I agree to pay \$ per hour, day, week, or month. Payments are to be made daily, weekly, semi-monthly monthly.

I agree to arrange for the necessary medical examination and immunizations for my child prior to or within 30 days after enrollment and I will provide updated immunization reports as required thereafter; or I will provide proper documentation for medical or religious exemption from these requirements.

I agree to pick up or arrange to have my child picked up as soon as possible when notified that he or she develops symptoms of a communicable disease; or

I have received a copy of the Information to Parents Statement.

I understand that someone other than the provider (e.g., substitute provider or assistant) will provide care % of the time my child is enrolled.

Other arrangements or acknowledgments:

Parent Signature Date Provider Signature Date 032-05-0401-00-eng