Model Form
Office of Child Care Health and Safety

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