



Registration Paid \$ _____

Payment Date: _____

Entered by: _____

Initial Visit: _____

Registration Form

How did you hear about us?

Parent/Guardian Information:

Parent #1

First & Last name: _____

Drivers License# _____ Family Password _____

Address _____

City _____ State _____ Zip _____

Home Ph _____ Cell Ph _____

Work Ph _____ E-Mail Address _____

Would you like to receive our monthly calendar via e-mail? YES NO

Circle Relationship: Parent Grand-Parent Step-Parent Foster Parent Relative Friend

Parent #2

First & Last name: _____

Drivers License# _____ Family Password _____

Address _____

City _____ State _____ Zip _____

Home Ph _____ Cell Ph _____

Work Ph _____ E-Mail Address _____

Would you like to receive our monthly calendar via e-mail? YES NO

Circle Relationship: Parent Grand-Parent Step-Parent Foster Parent Relative Friend



First & Last Name: _____

Child Birth Date _____ Sex _____

(Circle one)

Food or Medical Allergy: **Yes or No** _____

Take medications: **Yes or No** _____

Asthma: **Yes or No** _____

Speech/Communication Difficulty: **Yes or No** _____

Special Needs: **Yes or No** _____

Diaper Training: **Trained** **Diaper** **Training**

Please explain any YES answers from above and any special care needs that include, but not limited to, allergies, existing or previous illness or injuries, hospitalizations, medications prescribed for continuous use.

School Information: My child attends the following school and his/her immunization record is on file at the school and all immunizations, vision/hearing screen, tuberculosis test are current as required by Family Protective Services.

Name of School: _____

Address: _____

Phone Number: _____



In the event of an emergency and I or my spouse are unable to be reached, I authorize the following responsible persons to pick up my child/children or be contacted for information (cannot be parents):

Name Relationship to Child Phone Number

Name Relationship to Child Phone Number

Name Relationship to Child Phone Number

Emergency Medical Contacts and Consent for Medical Treatment: In the event I cannot be reached, I, or whoever signs my child in for that day (Authorized Representative to act as an agent for me), give my permission for Tick Tots Around the Clock to provide basic first aid to my child as reasonably appropriate, however, I understand Tick Tots Around the Clock shall not be required to strictly follow those guidelines when, in its judgment, circumstances may require otherwise. In the event that Tick Tots Around the Clock, in its sole discretion, believes that my child needs more advanced care, I consent to dental, medical, surgical, and/or hospital care, treatment, and/or procedures to be performed for my child by a licensed dentist, physician, ambulance attendant/emergency medical technician, or other licensed health care provider (collectively, "Health Care Professional") associated with a licensed treatment facility when deemed necessary or advisable by the Health Care Professional 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 Tick Tots Around the Clock to an emergency center for treatment. I certify my child is in excellent health and physical condition and has no medical, psychological, physical or mental condition which has not been disclosed to Tick Tots Around the Clock on the registration form. My child(ren) does not have any infectious, contagious or communicable diseases.

In the event my child is in need of emergency care, I do not require that the following physician or hospital be contacted. The information provided below is for informational purposes only. I consent to my child being taken to the treatment facility recommended by the Health Care Professional attending my child.

Name of Physician: _____

Office Address: _____

Phone Number: _____

Parent Signature

Date



Parent Policy and Release Form

Tick Tots Around the Clock must have a completed registration and parent policy and release form before children can be accepted for care. If children are not enrolled in a school, parents must also complete a parent's health statement or physician health statement form (a copy of the immunization records with a physician's health statement and physician's signature may be provided in place of the physicians health statement form) before the second visit. All children must be current on appropriate immunizations, vision and hearing screen requirements, and tuberculosis testing in order to be admitted to Tick Tots Around the Clock . We must have an updated immunization record or physician health statement form each year until the child enters school. Parents must advise Tick Tots Around the Clock of changes of address, phone numbers, and children's health and allergies. The costs are calculated to the minute. Payment is due at time of check-out. No refunds are given. The hours are our regular business hours, variations may occur due to holidays, maintenance and employee events. Any changes will be posted in advance in our lobby.

I represent that I am the parent or legal guardian of each child designated on this registration form. I, on behalf of myself, my spouse, and each child designated on the registration form (my "child"), hereby waive and release all rights, causes of action and claims against this independently owned/operated Tick Tots Around the Clock LLC, a Texas Corporation, its Officers, Directors, Agents, and Employees and all of its affiliates that I may visit for any loss, expense, damage or injury suffered by my child during the time my child is visiting Tick Tots Around the Clock, including the possible negligence of Tick Tots Around the Clock, but excluding gross negligence and intentional misconduct. I understand that the provision of child care contains risk of injury to persons and damage to property, and that by signing this release I engage Tick Tots Around the Clock to provide temporary childcare for my children at my own risk. I have been given an opportunity to inspect the premises of Tick Tots Around the Clock and found that it is safe and satisfactory for my child. I also have been given the opportunity to ask questions and obtain answers to my satisfaction regarding any and all aspects of Tick Tots Around the Clock and this Release. By signing this Release, I have not relied on any promises or statements made by Tick Tots Around the Clock or its employees other than those contained in written information supplied to me by Tick Tots Around the Clock. I understand this Release will be kept on file at Tick Tots Around the Clock and will continue in effect for this and any future visits my Child may make to Tick Tots Around the Clock.

I have read the above carefully and fully understand the content and consequences of this agreement and agree to abide by and be bound by the above policies and procedures and release.

Parent Signature

Date



Parent's Health Statement

Child's Name _____ Date of Birth _____

My child has been examined within the past year by a health care professional and is able to participate in the daycare program. I will provide a Physician's Health Statement within one year.

My child has an appointment for an examination with a licensed healthcare professional.

Date _____

Physician Name _____

Office Phone Number _____

Office Address _____

Medical diagnosis and treatment conflict with the tenets and practices of our recognized religious organization.

My child's immunization record is current and on file at the following listed school:

School _____

Address _____

Phone _____

I have provided the childcare center with a copy of my child's current immunization record.

Parent Signature

Date