Day by Day Child Development Center, Inc.
1565 Cliff Road, Suite 9
Eagan, MN 55122
651-405-8005

Enrollment and Emergency Contact Record

Child's Date of Enrollment: _____

Child's Name: _____ DOB: _____
Child's Address: _____
Home Phone Number: _____

Mother's Name: _____
Mother's Address (if different than childs): _____
Mother's Employer: _____
Mother's Email Address: _____
Mother's Phone Numbers: Cell: _____ Work: _____
Best Number to reach you at during the day: Home Cell Work (circle one)
Text Messages: Yes No Cell Phone Provider: _____

Father's Name: _____
Father's Address (if different than childs): _____
Father's Employer: _____
Father's Email Address: _____
Father's Phone Numbers: Cell: _____ Work: _____
Best Number to reach you at during the day: Home Cell Work (circle one)
Text Messages: Yes No Cell Phone Provider: _____

If neither parent can be reached in case of emergency contact one of the following: (at least two)

Name(s): _____ Relationship to child: _____
Address: _____
Phone numbers: Home: _____ Work: _____
Cell:_____ Cell:_____
Authorized to pick-up child from school: YES NO

Name(s): _____ Relationship to child: _____
Address: _____
Phone numbers: Home: _____ Work: _____
Cell:_____ Cell:_____
Authorized to pick-up child from school: YES NO

Name(s): _____ Relationship to child: _____
Address: _____
Phone numbers: Home: _____ Work: _____
Cell:_____ Cell:_____
Authorized to pick-up child from school: YES NO

Name(s): _____ Relationship to child: _____
Address: _____
Phone numbers: Home: _____ Work: _____
Cell:_____ Cell:_____
Authorized to pick-up child from school: YES NO

Name(s): _____ Relationship to child: _____
Address: _____
Phone numbers: Home: _____ Work: _____
Cell:_____ Cell:_____
Authorized to pick-up child from school: YES NO

Persons **NOT authorized** to pick-up child from school:

Name: _____ Relationship to child: _____
Name: _____ Relationship to child: _____

Child's Doctor:
Name: _____
Clinic Name: _____
Address: _____
Phone number: _____

Child's Dentist:
Name: _____
Clinic Name: _____
Address: _____
Phone number: _____

Medical Information:

Allergies: _____
Injuries: YES NO Type: _____
Major Illnesses: YES NO What Kind: _____
Vision Difficulty: YES NO Wears glasses: YES NO
Hearing Difficulty: YES NO Ear tubes: YES NO left right both
Speech Difficulty: YES NO Explain: _____
Other: _____

Other Comments/Concerns: _____

_____

_____