Buzybeez Preschool

Kimberly Steele
1804 N.E. 168th St.
Shoreline, WA.98155
1.206.595.4013

Child Care Registration Form		Date child entered care	Date child left care
Child's name (Last, First, Middle)	Name used (Nickname)		Birthdate
Street address	City		Zip code

Child's parent/guardian name	Circle the best number to contact you at when your child is in our care		
	cell phone #	home phone #	alternate phone #
Street address	City		Zip code

Child's parent/guardian name	Circle the best number to contact you at when your child is in our care		
	cell phone #	home phone #	alternate phone #

I give my permission for any of the following individuals to be contacted and my child may be released to any of them.
Parent/Guardian signature: _____ *Date:* _____ **In an emergency, if you are not able to contact me, contact the following:**

Name (first and last)	cell phone #	home phone #	alternative phone #

These individuals also have permission to pick up my child:

Name (first and last)	cell phone #	home phone #	alternative phone #

Child's health information	
Child's medical care provider or parent's/guardian's preferred medical facility for treatment Name: Phone: Street Address:	Child's last physical exam, if available
Child's dental care provider or parent's/guardian's preferred dental facility for treatment Name: Phone: Street Address:	Child's last dental exam, if available

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Consent to medical care and treatment of minor children			
I give permission that my child, _____ may be given first aid/emergency treatment by the childcare licensee and or qualified staff at: Name of Licensee: _____ Address of Licensee: _____			
Parent/guardian signature	Date	Parent/guardian signature	Date
When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid care attendant 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 aid car to an emergency center for treatment. I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.			
Parent/guardian signature	Date	Parent/guardian signature	Date
Known health conditions (An individual care plan from child's health care provider is required for any food allergies or special dietary requirement due to a health condition.)			

CHILD CARE REGISTRATION FORM
DCYF 15-879 (REV. 6/2021) EXT