Model Form
Division of Licensing Programs

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