	For office use only	
Date of enrollment	Start date	Withdrawal date

Little Lambs Learning Center Registration Form

Please make sure to fill in all lines. If there is no information available please write "none"

Last name:	First name:	M.I.:
Goes by (nickname):	Date o	f birth:
Allergies or special need	S:	
Has this child ever been in chi	ildcare/preschool before? Yes	No
Has this child ever had any se	rious illness or accidents? If so please	e list and give date.
Any recent changes in the chil	ld's life: (divorce, new baby, death, mo	oving, etc.)
•	oth Mom & Dad Mom Dad	Other
_	e are:	
	us to know about your child or family	
Mother's Information:		
Last name:	First name:	
Address:	City:	Zip:
11dd1 C55.		
	Cell phone:	
	Cell phone:	
Home phone:	Cell phone:	
Home phone: Email address: Employer:	Cell phone:	
Home phone: Email address: Employer:	Cell phone:	
Home phone: Email address: Employer:	Cell phone:	
Home phone: Email address: Employer: Address: Father's Information:	Cell phone:	ext
Home phone: Email address: Employer: Address: Father's Information: Last name:	Cell phone: Phone:	ext
Home phone: Email address: Employer: Address: Father's Information: Last name: Address:	Cell phone: Phone: First name:	ext Zip:
Home phone: Email address: Employer: Address: Father's Information: Last name: Address: Home phone:	Cell phone: Phone: First name: City: Cell phone:	ext Zip:
Home phone: Email address: Employer: Address: Father's Information: Last name: Address: Home phone: Email address:	Cell phone: Phone: First name: City:	ext Zip:

(Please continue on reverse side)

Name: Relationship to child: Home phone: _____ Vork phone: ____ Cell phone: ____ Name: Relationship to child: Name: _____ Relationship to child: _____ In addition to us as parents and the emergency contacts listed above, the people listed on the lines below are allowed to pick my child up from Little Lambs Learning Center. I understand that I will be responsible for making sure that anyone picking up my child will be required to bring proof of identity with them when the pick up my child. Please make sure to fill in all lines below. If there is no information available please write "none" Name of primary physician: _____ Phone _____ Address: _____ City _____ Hospital preferred for emergency treatment: I give permission to Little Lambs Learning Center staff, licensed by the Department of Consumer and Industry Services, to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care. Date Signature Authority:1973 PA 116 Completion: Required Penalty: Rule Violation Citation Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area. Revised 4/23/2018

Initials

Date reviewed

Initials

Date reviewed

Date reviewed

Initials

Date reviewed | Initials

Initials

Date reviewed

Emergency Contact Information: In the event that I cannot be reached for notification of either illness or injury, the following people can be notified to pick up my child and care for them until I can be reached (We need at least 2).