



NEW CHILD: REGISTRATION APPLICATION

STUDENT INFORMATION						
Student's Name Last	First	Middle	Gender	Date of Birth	Start Date	Exit Date
Street Address				City	State	Zip
How did you hear about SCP?						
PARENT/GUARDIAN INFORMATION						
Parent/Guardian Name Last					Relationship to Student:	
Street Address					City	State
Home Phone		Cell Phone		Work Phone		Email
Employer		Employer Address		City	State	Zip
Parent/Guardian Name Last					Relationship to Student:	
Street Address					City	State
Home Phone		Cell Phone		Work Phone		Email
Employer		Employer Address		City	State	Zip
EMERGENCY CONTACTS						
The emergency contacts are always authorized for pick-up of child in case of emergency. (ID required for pickup)						
Name		Address			Phone Numbers	
Full Name:					Home:	
Relationship:					Cell:	
					Work:	
Full Name:					Home:	
Relationship:					Cell:	
					Work:	
Full Name:					Home:	
Relationship:					Cell:	
					Work:	
Full Name:					Home:	
Relationship:					Cell:	
					Work:	
<i>If you need to add more emergency contacts, please inquire about an additional form.</i>						
ADDITIONAL FAMILY INFORMATION						
Please let us know about shared custody situations so we can be sensitive to your child.						
Is there a restraining order in effect? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(If yes, court documentation must be on file with SCP for enforcement).</small>						
Is there is parenting plan in effect? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(If yes, court documentation must be on file with SCP for enforcement).</small>						



NEW CHILD: REGISTRATION APPLICATION

HEALTH HISTORY			
Doctor's Name:	Address:	Phone Number:	Last Physical Exam Date:
Dentist Name:	Address:	Phone Number:	Last Dental Exam Date:
Insurance Company Name:		Member/Policy Number:	
Policy Holder Name:		Employer Name:	
<p>INDIVIDUAL HEALTH CARE PLAN: Does your child have a life-threatening medical condition, severe allergies, or significant health/development concerns? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><i>If yes please explain below</i></p> <p>If you answered yes to any of the questions below, you will be contacted regarding other required forms. Forms/on-site training must be completed and submitted no later than a week before start date.</p>			
<p>Please check all that apply to your child:</p> <p><input type="checkbox"/> Food Allergies <input type="checkbox"/> Medical Allergies <input type="checkbox"/> Other Allergies <input type="checkbox"/> Developmental Needs (Speech/PT/OT)</p> <p>Does your child have an Epi-Pen or Inhaler? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>			
<p>I will provide a daily snack due to my child's food preferences.</p> <p>Initials: <input style="width: 50px; height: 20px;" type="text"/></p> <p>If snack is not provided from home, SCP will provide a snack.</p> <p>Initials: <input style="width: 50px; height: 20px;" type="text"/></p>			