



Stepping Stones Discovery & Development Center A Step Ahead !

Child's Name: _____
Mother Name: _____
Father Name: _____
Address: _____
City/Zip Code: _____ / _____
Mother's Employer: _____
Father's Employer: _____
Father's Address (if different): _____

Nick Name: _____
Child's Birth date: _____ Sex: M F
Mother's Cell: _____
Father's Cell: _____
Mother's work#: _____
Father's work#: _____
Home Phone: _____
Other Phone: _____
email: _____

Weekly Care Schedule

Start Date: _____
Monday: _____
Tuesday: _____
Wednesday: _____
Thursday: _____
Friday: _____

maximum hour for full time 47.5 hours a week (9.5 hrs a day)

Emergency Contacts

Name: _____
Address: _____
Phone: _____
Relationship: _____

Is this person authorized to make medical decisions for your child if you can't be reached? Y N

Name: _____
Address: _____
Phone: _____
Relationship: _____

Is this person authorized to make medical decisions for your child if you can't be reached? Y N

Medical Contacts

Child's Doctor: _____
Address: _____
Phone: _____
Child's dentist: _____
Address: _____
Phone: _____

Authorized Pick-up

Name: _____
Address: _____
Phone: _____
Relationship: _____

Name: _____
Address: _____
Phone: _____
Relationship: _____

Note: Any person unfamiliar to staff will be required to show a picture ID.

Limitations

Please indicate any limitations, restrictions, or concerns you may have for your child (ie. Allergies, medications, medical conditions, ect.) _____

I authorize Stepping Stones Discovery & Development Center Staff to obtain emergency medical treatment for my child should the need arise. I assume all financial responsibility that may be required for treatment. To the best of my knowledge the information provided above is accurate.

Parent/ Guardian Signature: _____ Date: _____