BREEZE-IN, DROP-OFF CHILD

REGISTRATION FORM

Please print neatly!

Date:

PARENT/GUARDIAN : First Name, Last Name ____

Circle Relationship: Parent Grandparent Step-Parent Foster-Parent Relative

Child's First Name, Last Name____ Home (____)____________________

Address ____Apt #_______ Cell (____)_____________________

City _______________________ State ____ Zip ___________DL License # _____________________ State________ Work (____)____________________

Delta Student ID Number__________________

Children's Doctor/Hospital Name / Phone____(____)____________________________

Location/Date/Time of appointment(s) on Delta Campus____

FAMILY CONTACTS

Must list at least one contact other than parents as an Emergency Contact

First Name__________________________________ Last Name____ Home (____)________________

Address ____Apt #_______ Cell (____)_________________

City _______________________ State ____ Zip ____________ License # _____________________ State________ Work (____)________________

Circle Relationship: Parent Grandparent Step-Parent Foster-Parent Relative A friend Emergency Contact? Yes No

First Name__________________________________ Last Name____ Home (____)________________

Address ____Apt #_______ Cell (____)_________________

City _______________________ State ____ Zip ____________ License # _____________________ State________ Work (____)________________

Circle Relationship: Parent Grandparent Step-Parent Foster-Parent Relative A friend Emergency Contact? Yes No

CHILD INFORMATION

	CHILD #1 Name: Birthdate: Sex: M F	CHILD #2 Name: Birthdate: Sex: M F	CHILD #3 Name: Birthdate: Sex: M F
Dietary Restrictions			
1. Food Allergies?	Yes No	Yes No	Yes No
2. Other Dietary Restrictions?	Yes No	Yes No	Yes No
Medical			
3. Medicine Allergies?	Yes No	Yes No	Yes No
4. Insect Bite Allergies?	Yes No	Yes No	Yes No
5. Other Allergies?	Yes No	Yes No	Yes No
6. Take Medications?	Yes No	Yes No	Yes No
7. Asthma?	Yes No	Yes No	Yes No
8. Hearing/Vision Problems?	Yes No	Yes No	Yes No
9. Past Health Problems?	Yes No	Yes No	Yes No
Other Problems			
10. Activity Restrictions?	Yes No	Yes No	Yes No
11. Special Routines?	Yes No	Yes No	Yes No
12. Usually Take a Nap?	Yes No	Yes No	Yes No

Please explain any Yes answers, noting Child's name and question number:____

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SIGNATURE REQUIRED____DATE:__________________________