Happy Hearts Montessori School

KENT SCHOOL

info@happyheartsmontessori.com
26829 119th Ave SE, Kent, WA 98030
(253) 802-6657| (253) 709-5988

TODDLER REGISTRATION FORM 2023-2024

Date Child Entered Care:			
Child's Name (Last, First, Middle)		Name Used (Nickname)	Birthdate
Street Address		City	Zip Code
Child's Parent/Guardian Name 1	Cell Phone# ( ) -	Home Phone# ( ) -	Alternate Phone# ( ) -
Street Address		City	Zip Code
Email Address			
Child's Parent/Guardian Name 2	Cell Phone# ( ) -	Home Phone# ( ) -	Alternate Phone# ( ) -
Street Address		City	Zip Code
Email Address			

I give my permission for any of the following individuals to be contacted and my child may be released to any of them.

Parent/Guardian Signature:_____ Date:_____

In an emergency, if you are not able to contact me, contact the following:

Name (First and Last)	Cell Phone#	Home Phone#	Alternative Phone#

These individuals also have permission to pick up my child:

Name (First and Last)	Cell Phone#	Home Phone#	Alternative Phone#

Child's Health Information

Child's medical care provider or parent's /guardian's preferred medical facility for treatment Name _____ Phone:( )- _____ Address: _____	Child's Last Physical Exam Date (If available)
Child's dentalcare provider or parent's/guardian's preferred medical facility for treatment. Name _____ Phone:( )- _____ Address: _____	Child's Last Dental Exam Date (If available)

Known Health Conditions (An individual care plan from child's health care provider is required for any food allergies or special dietary requirement to a health condition)

Consent to Medical Care and Treatment of Minor Children

I give permission that my child _____may be given first aid/emergency treatment by the child care licensee and or qualified staff at:

Name of Licensee: _____

Address of Licensee_____

Parent/Guardian Signature	Date	Parent/Guardian Signature	Date

When I cannot be contacted, I authorize and consent to medical, surgical, and hospital care, treatment, and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid care attendant, when deemed necessary or advisable by the physician or care attendant to safeguard my child's health. I waive my right of informed consent to such treatment.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

I certify under penalty of perjury under the laws of the state of Washington that this information is true and correct.

Parent/Guardian Signature	Date	Parent/Guardian Signature	Date