Registration Form

Childs Name: ____ D.O.B. ______________

Parent Name: ____

Cell: ________________ Alternate Phone: _____________ Email: ________________

Address: ____________________________ City: ________________ State: _________

Parent Name: ____

Cell: ________________ Alternate Phone: _____________ Email: ________________

Address: ____________________________ City: ________________ State: _________

Special Instructions

Diapers:______________________ Potty training_________________ Reminder__________________

Allergies: (Please alert staff each time you drop off)

List: ___________________________________ List____

Epi Pen provided (YES)_____(NO)_____

Snacks: It is ok to give my child a snack if he would like one (YES) _____ (NO)_____

I will provide snacks (YES)_____(NO)_____

Does your child have any special needs? (YES)_____(NO)_____

Other Instructions:____

____

____

Pick-Up Authorization

I give the following individuals permission to pick up my child. I understand that I **MUST** give authorization either in person or by phone each and every time my child is picked up by an authorized adult. _____ (initial)

Pick Up Name	Relationship to Child	Notes

Emergency Contact

In the event of an emergency and we are unable to reach the parent/guardian listed on these forms I authorize the following physician or health care facility to be contacted.

______ (initial)

Name	Address	Phone

Consent for Medical Treatment:

In the event of a serious emergency, we will dial 911

In the event I cannot be reached, I, or whoever signs my child in for that day (Authorized Representative to act as an agent for me), give my permission for The Children's Depot/ preschool to provide basic first aid to my child as reasonably appropriate, however, I understand that the Children's Depot shall not be required to strictly follow those guidelines when, in its judgment, circumstances may require otherwise.

_____ (initial)

In the event that the Children's Depot in its sole discretion, believes that my child needs more advanced care, and the emergency contact from above cannot be reached; I consent to dental, medical, surgical, and/or hospital care, treatment, and/or procedures to be performed for my child by a licensed dentist, physician, ambulance attendant/emergency medical technician, or other licensed health care provider (collectively, "Health Care Professional") associated with a licensed treatment facility when deemed

Consent for Medical Treatment (continued):

necessary or advisable by the Health Care Professional to safeguard my child's health. I waive my right of informed consent to such treatment.

_____ (initial)

I also give my permission for my child to be transported by ambulance to an emergency center for treatment. I certify my child is in excellent health and physical condition and has no medical, psychological, physical or mental condition which has not been disclosed to The Children's Depot on the registration form. My child does not have any infectious, contagious or communicable diseases. In the event my child is in need of emergency care, I do not require that the following physician or hospital be contacted. The information provided below is for informational purposes only.

_____ (initial)

I consent to my child being taken to the treatment facility recommended by the Health Care Professional attending my child.

_____ (initial)

Parent Signature ____Date_______________________

Photo Release:

As the parent of a child at The Children's Depot, I agree to the following:

- I understand that my child whose name is listed on this registration may be photographed at The Children's Depot during normal daycare hours or activities.
- I understand that these photographs may be used in newsletters or mounted on the The Wave Aquatic and Fitness Center/Children's Depot website and/or Facebook page.
- I give permission for my child's photographs to be mounted on The Wave Aquatic and Fitness Center/Children's Depot Facebook page, or newsletters. (When names are added, only first names will be used.)

( ) Yes, I confirm that I have read and understood the above, and agree to have my child's photographs to be mounted on The Wave Aquatic and Fitness Center/Children's Depot Facebook page, or newsletters.

( ) No, I do not wish to have my child's photographs published Name (please print)

Signature: ____ Date:____________________________

Release of Liability

I represent that I am the parent or legal guardian of the child designated on this registration form. I, on behalf of myself, my spouse, and the child designated on the registration form (my “child”), hereby waive and release all rights, causes of action and claims against The Wave Aquatic Health and Fitness Center, its Officers, Directors, Agents, and Employees and all of its affiliates, for any loss, expense, damage or injury suffered by my child during the time my child is visiting the Wave, including the possible negligence of The Wave aquatic Health and Fitness, but excluding gross negligence and intentional misconduct. I understand that the provision of child care contains risk of injury to persons and damage to property, and that by signing this release I engage The Children’s Depot to provide temporary childcare for my children at my own risk. I have been given an opportunity to inspect the premises of The Children’s Depot and found that it is safe and satisfactory for my child. I also have been given the opportunity to ask questions and obtain answers to my satisfaction regarding any and all aspects of The Children’s Depot and this Release. By signing this Release, I have not relied on any promises or statements made by The Children’s Depot or its employees other than those contained in written information supplied to me by The Children’s Depot. I understand this Release will be kept on file at the Children’s Depot and will continue in effect for this and any future visits my Child may make to The Children’s Depot. I have read the above carefully and fully understand the content and consequences of this agreement and agree to abide by and be bound by the above policies and procedures and release.

Parent Signature ____**Date**______________________

Parent's Health Statement

Date____

Child's Name____

D/O/B____

Please Check One of these:

◯ My Child has been examined within the past year by a health care professional and is able to participate in a child care program/preschool program. I will provide a physicians health statement which includes an updated immunization records.

◯ My Child has an appointment for an examination with a licensed health care physician professional, and I will provide the physicians health statement by my next visit.

◯ My child's immunization record is current and on file at the following school

School____

Address____

Phone number____

Doctor Name: ____

Parent's Signature: ____

Print Name: ____

Child Care Immunization History

Date____

Child's Name____

D/O/B____

Valid only when filled out by School, Child Care or Medical Personnel (NOT to be filled out by the parent)

Required Vaccines	Month, Day & Year of Each Dose				
	1	2	3	4	5
Diphtheria/Tetanus/Pertussis(DTaP)					
Hacmophilus Influenzac Type B (Hib) (Only children less than 5 years)					
Measles/Mumps/Rubella (MMR)					
Measles vaccine only					
OR Mumps vaccine only					
Rubella vaccine only					
Polio (IPV or OPV)					
Varicella (Chickenpox) [VZV or VAR] ○ **Check here if child has documentation of disease**					

If filled out by health department or health care provider:

To the best of my knowledge, this child has received the above immunizations.

Signed: ____
(Health Department/Health Care Provider) Date

Signed: ____
(Health Department/Health Care Provider) Date

Signed: ____
(Health Department/Health Care Provider) Date

Signed: ____
(Health Department/Health Care Provider) Date

Signed: ____
(Health Department/Health Care Provider) Date

If filled out by school or child care personnel:

I CERTIFY this information has been transferred from supporting documentation as stated in the Administrative Rules of Montana.

Signed: ____
(Health Department/Health Care Provider) Date

Signed: ____
(Health Department/Health Care Provider) Date

Signed: ____
(Health Department/Health Care Provider) Date

Signed: ____
(Health Department/Health Care Provider) Date

Signed: ____
(Health Department/Health Care Provider) Date