Bright Horizons FAMILY SOLUTIONS®

FORM

# Child Information Form

Child's Name: _____ Primary Language: _____

Child's Address: _____
Street City/Town Zip Code

Place of Birth: _____ Date of Birth: _____/_____/_____

Child's Schedule: MON _____ TUE _____ WED _____ THU _____ FRI _____

**Parent/Guardian Information**

Name:_____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

_____ _____

Home E-mail Address: _____ Home E-mail Address: _____

Cell Phone: _____ Cell Phone: _____

Home Phone: _____ Home Phone: _____

Others in Family Relationship: _____

**Parent/Guardian Business Information**

Company Name: _____ Company Name: _____

Address: _____ Address: _____

_____ _____

Business Phone: _____ Business Phone: _____

E-mail Address: _____ E-mail Address: _____

**Medical Information**

Eye Color: _____ Hair Color: _____ Height: _____ Weight: _____ Race: _____ Gender ☐M ☐F

Identified Allergies: _____

Identifying Marks: _____

Health Insurance Provider: _____

**Physician/Dentist Information**

Name of Physician/Clinic: _____ Phone: _____

Physician Address: _____
Street City/Town Zip Code

Date of Child's Last Physical **(WA State Only)**: _____

Name of Dentist: _____ Phone: _____

Dentist Address: _____
Street City/Town Zip Code

Parent/Guardian Signature: _____ Date: _____

**FOR CENTER USE:** Center: _____ Date of Admission_____ Age of Admission: _____

Date Registration Fee Rec'd:_____ Director's Initials: _____