# PARISH NAME

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## DIOCESE OF TUCSON

## AT-PARISH CHILD CARE ANNUAL REGISTRATION FORM

**This registration form is valid from ________/_____/ 20___ to ________/_____/20___.**

Child's Name ______________________________ Sex _______ Date of Birth ____________________
Child must be at least 12 months old

Street Address ______________________________ Home Telephone ____________________

______________________________________________________________

Apt # City State Zip

Father's Name ______________________________ Place of Employment ______________________________

Work Phone ______________________________ Mobile Telephone ______________________________

Mother's Name ______________________________ Place of Employment ______________________________

Work Phone ______________________________ Mobile Telephone ______________________________

The following individuals are authorized to pick up my child or be notified in case of emergency if parents cannot be reached:
**Note: Authorized individuals must show photo identification when picking up child**

Name ______________________________ Telephone ______________________________

Name ______________________________ Telephone ______________________________

Family Doctor's Name ______________________________ Telephone ______________________________

Family Dentist's Name ______________________________ Telephone ______________________________

Hospital Preference ______________________________________________________________

Health Insurance Plan ______________________________ Policy No. ______________________________

Allergies ______________________________________________________________

Medical Conditions, Special Needs, Restrictions: ______________________________

______________________________________________________________

### AUTHORIZATION TO TREAT A MINOR

I (we) the undersigned parent/ parents or legal guardian of ______________________________ a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general supervision of any licensed member of the medical staff and emergency room staff, or a dentist licensed and on the staff of any acute general hospital holding a current license to operate a hospital from the State Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment of hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. **It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.**

List restrictions: ______________________________________________________________

______________________________________________________________

______________________________________________________________

Signature of Father, Mother, or Legal Guardian Date

______________________________________________________________

Address City State Zip

**MAKE ONE COPY OF COMPLETED FORM. FILE "COPY" AT PARISH. PLACE ORIGINAL IN HEALTH INFORMATION BINDER WHICH CHILD CARE MINISTER SHALL MAINTAINED IN HER/HIS POSSESION.**