GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION

PLEASE PRINT OR TYPE

REGISTRATION RECORD FOR CHILD RECEIVING CARE AWAY FROM HOME

Child: ______________________ Sex: ☐ Male ☐ Female
Last First M.I.

Date of Birth: ____________ Home # ____________

Home Address: ______________________
Number Street Apt # State ZIP

Father: ______________________ Home # ____________
Last First M.I. Business # ____________

Home Address: ______________________
Number Street Apt # State ZIP

Business Address: ______________________
Number Street Apt # State ZIP

Mother: ______________________ Home # ____________
Last First M.I. Business # ____________

Home Address: ______________________
Number Street Apt # State ZIP

Business Address: ______________________
Number Street Apt # State ZIP

Relative or Guardian: ______________________ Home # ____________
Last First M.I. Business # ____________

Home Address: ______________________
Number Street Apt # State ZIP

Business Address: ______________________
Number Street Apt # State ZIP

Person to be contacted in case of an emergency: – if parent cannot be reached.

______________________ Relationship to child: ____________
Last First M.I.

Address: ______________________
Number Street Apt # State ZIP Phone #

Designated individual authorized to receive child at end of session:

____
Last First M.I.

____
Last First M.I.

____
Last First M.I.

Signature: ____________ **Relationship to child:** ____________ **Date:** ____________

TO BE COMPLETED BY THE FACILITY

Date of Admission: ____________

Date of Withdrawal: ____________ **Reason:** ____________

PLEASE RETAIN A COPY FOR YOUR RECORDS