THE FAMILY PARTNERSHIP

Intake Staff / Contact Number	**Intake Fax Line:**
Four Directions (4D) Mary – Director: 612-722-0766 Kelly: 612-314-2938 Marilyn: 612-722-0767	**4D:** (612) 722-0787

Publicity Release :	**Yes / No**

Child Registration/Emergency Contact Form

PROGRAM: ☐4D	**CLASSROOM**	**REFERRAL/FUNDING SOURCE**	**START DATE**	**TERMINATION DATE**

CHILD/ENROLLEE				
First Name		Last Name	Date of Birth	
Address	Apt Number		City/State/Zip	
Social Security Number		Gender	Race/Ethnicity/Tribe	
Cell Phone/Home Phone		Resides with	Language spoken in home	Interpreter needed?
PARENT/GUARDIAN 1				
First Name		Last Name	Date of Birth	County Born
Current Address	☐Rent ☐Own		City/State/Zip	
Social Security Number		Race/Ethnicity/Tribe	Relationship to child	
Cell Phone:	Home Phone	Email Address	Work/School	
PARENT/GUARDIAN 2				
First Name		Last Name	Date of Birth	County Born
Current Address	☐Rent ☐Own		City/State/Zip	
Social Security Number		Race/Ethnicity/Tribe	Relationship to Child	
Cell Phone:	Home Phone	Email Address	Work/School	

SIBLINGS NAME	**DOB**	**RESIDES WITH**

JOB COUNSELOR / CHILDCARE ASSISTANCE WORKER/CHILD PROTECTION WORKER

NAME	COMPANY NAME	CONTACT NUMBER
Job Counselor		
Childcare Assistance Worker		
Child Protection Worker		

MFIP Case Number(if applicable)

MEDICAL

Health Care Provider/ Clinic	Address	Contact Number
Dental Care Provider/Clinic	Address	Contact Number

Asthma ☐YES ☐NO If Yes, Action Plan in file ☐YES ☐NO

Allergies to Foods ☐YES ☐NO If Yes, Please list

Allergies to Medications ☐YES ☐NO If Yes, Please list

Medications

Medical/Mental Health issues or environmental needs we should know about?

INSURANCE

Family Size	# of children in household	Family Income: ☐ Annual ☐ Monthly

Insurance Name	ID #
Phone #	Group #
MFIP Case Number(if applicable)	

EMERGENCY CONTACT INFORMATION/AUTHORIZED PERSONS TO DROP OFF & PICK UP CHILD ***(IMPORTANT: They MUST be at least 16 years old, have a valid photo ID, address and a working phone number.) (Must have at least two listed.)***

Name	Address	Relationship	Contact Number

Is anyone *NOT* allowed to pick up child? If yes, please list NAME and Explain Why.

DESIRED START DATE	DAYS & HOURS

Is there anything you feel you may need help with? (Parent education, housing, mental health, depression, chemical dependency, ect) If yes, please explain below.

I give permission to Four Directions to make whatever emergency (i.e. first aid, disaster evacuation) measures judged necessary for the care and protection of my child. In case of a medical emergency, I understand that my child will be transported to an appropriate medical facility by the local emergency for treatment if deemed necessary. My child will be transported at the expense of:

_____ (List your Health Insurance provider)

_____

Parent/Guardian Signature **Date**

For office use only

Start Date: _____ End date: _____ Client ID_____

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