Intake Staff / Contact Number
N Mpls:
Cassaundra – Director: 612-294-2659
Brandy: 612-294-2659

Intake Fax Line:
North Mpls: (763) 521-3893

Publicity Release :	Yes / No

Child Registration/Emergency Contact Form

PROGRAM: ☐TFP North Mpls	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 The Family Partnership North Minneapolis preschool, SEA, or FDFC 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**_____________________

Rev. 8/4/20