

Family Day Care Admission and Arrangements



Please Print. Complete one form for each child. *This form must be kept on file at the family day care home.*

The information requested on this form is necessary for proper care of your child. You are not legally required to supply this information; however, failure to do so will make you ineligible to receive family day care services from a licensed provider (MN Rule, Parts 9502-0300 to 9502-0445 Formerly Rule 2). The information requested will be maintained in a private manner and will not be released to anyone other than the licensing consultant without your prior written approval.

This information is available in other forms to people with disabilities by contacting us at (651) 296-3971. TTY/TDD users can call the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.

| | | | |
|---|-----------|---------------------------------------|-----|
| 1. NAME OF DAY CARE PROVIDER(S) (LAST, FIRST, MIDDLE) A. | | 2. CHILD'S NAME (LAST, FIRST, MIDDLE) | |
| ADDRESS B. | | DATE OF BIRTH | AGE |
| NAME OF SUPERVISING AGENCY | TELEPHONE | 3. REFERRED BY | |

| 4. Parent Information | Mother | Father |
|-----------------------|--------|--------|
| NAME | | |
| PLACE OF EMPLOYMENT | | |
| ADDRESS OF EMPLOYMENT | | |
| WORK TELEPHONE | | |
| HOME ADDRESS | | |
| HOME TELEPHONE | | |

| 5. Responsible friend/relative to call if parents cannot be reached | 6. Names of all persons authorized to remove child from home |
|---|--|
| NAME | |
| ADDRESS | |
| TELEPHONE | RELATIONSHIP |

7. The following licensed physician is authorized to give emergency care to my child.

| | | |
|------------------------------------|------------------|-----------|
| PHYSICIAN'S NAME | ADDRESS | |
| TELEPHONE | CITY, STATE, ZIP | |
| NAME OF PARENT'S INSURANCE COMPANY | CONTRACT NO. | GROUP NO. |

IF UNAVAILABLE, ANOTHER LICENSED PHYSICIAN MAY TREAT MY CHILD YES NO

The following licensed dentist is authorized to give emergency care to my child.

| | | |
|------------------------------------|------------------|-----------|
| DENTIST'S NAME | ADDRESS | |
| TELEPHONE | CITY, STATE, ZIP | |
| NAME OF PARENT'S INSURANCE COMPANY | CONTRACT NO. | GROUP NO. |

IF UNAVAILABLE, ANOTHER LICENSED DENTIST MAY TREAT MY CHILD. YES NO

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| 8. FINANCIAL ARRANGEMENTS |
| 9. SERVICES PROVIDED (INCLUDING DAYS, HOURS, MEALS, ETC.) |
| 10. SPECIAL CONDITIONS (SPECIAL DIET, SPECIAL NEEDS) |
| 11. INFANT SCHEDULE |
| 12. AUTHORIZATION IS HEREBY GIVEN TO THE DAY CARE PROVIDER AS NAMED IN ITEM 1. ABOVE, TO PROVIDE TRANSPORTATION FOR MY CHILD. <input type="checkbox"/> YES <input type="checkbox"/> NO |

AUTHORIZATION: We the undersigned hereby agree to abide by the arrangements and authorizations so stated above. We have discussed the information required le part 9502.0405.

| | | | |
|--------------------------------|------|-------------------------------------|------|
| SIGNATURE OF DAY CARE PROVIDER | DATE | SIGNATURE OF PARENT ADMITTING CHILD | DATE |
|--------------------------------|------|-------------------------------------|------|