

**MILDLY ILL CHILD CENTER SERVICES**  
**through BryanLGH MEDICAL CENTER**  
**CHILD DEVELOPMENT CENTER**  
**REGISTRATION FORM**

CHILD'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

PLEASE COMPLETE ALL SECTIONS

**SECTION I: Parent or Guardian's home and employment address.**

**PARENT/LEGAL GUARDIAN 1:**

Name \_\_\_\_\_ Employer \_\_\_\_\_  
 Address \_\_\_\_\_ Address \_\_\_\_\_  
 City/Zip \_\_\_\_\_ City/Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Dept./Ext \_\_\_\_\_

**PARENT/LEGAL GUARDIAN 2:**

Name \_\_\_\_\_ Employer \_\_\_\_\_  
 Address \_\_\_\_\_ Address \_\_\_\_\_  
 City/Zip \_\_\_\_\_ City/Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Dept./Ext \_\_\_\_\_

WHO SHOULD BE PRIMARY CONTACT: \_\_\_\_\_  
 (The center prefers the employee but would comply with request) If only one guardian identified, would there be another person claiming guardianship coming to pick up? \_\_\_\_\_

**SECTION II:**

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Allergies/Medical Conditions \_\_\_\_\_

I hereby consent to use the Bryan Emergency Department should a situation arise that warrants immediate medical attention. I understand that all charges incurred will be my responsibility or the responsibility of my insurance carrier.

\_\_\_\_\_  
 Parent/Guardian Signature Date

**SECTION III: Certificate of Immunization - Month and Year of Each Dose**

DTP/Td		ORAL POLIO		HIB	
DATE	GIVEN BY	DATE	GIVEN BY	DATE	GIVEN BY
1.		1.		1.	
2.		2.		2.	
3.		3.		3.	
4.		4.		<b>MMR</b>	
5.		--	--	DATE	GIVEN BY
--	--	--	--	1.	

I certify that this information is correct to the best of my knowledge.

\_\_\_\_\_  
 Parent/guardian Signature Date

**MILDLY ILL CHILD IN HOME SERVICES**  
**through BryanLGH MEDICAL CENTER**  
**CHILD DEVELOPMENT CENTER**  
**REGISTRATION FORM**

CHILD'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

PLEASE COMPLETE BOTH SECTIONS

**SECTION I: Parent or Guardian's home and employment address.**

**PARENT/LEGAL GUARDIAN 1:**

Name _____	Employer _____
Address _____	Address _____
City/Zip _____	City/Zip _____
Phone _____	Dept./Ext. _____

**PARENT/LEGAL GUARDIAN 2:**

Name _____	Employer _____
Address _____	Address _____
City/Zip _____	City/Zip _____
Phone _____	Dept./Ext. _____

WHO SHOULD BE PRIMARY CONTACT: \_\_\_\_\_

(The center prefers the employee but would comply with request) If only one guardian identified, would there be another person claiming guardianship coming to pick up? \_\_\_\_\_

**SECTION II:**

Physician Name \_\_\_\_\_

Phone \_\_\_\_\_

Allergies/Medical \_\_\_\_\_ Conditions: \_\_\_\_\_

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\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date