



GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF HEALTH  
HEALTH CARE REGULATION AND LICENSING ADMINISTRATION



C&RCFD 045 REV 07/04

**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:**

\_\_\_\_\_ 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**