Queen B's Infant and Childcare

For inquires call: 630 456 3581

Child Information

Name First/Last: _____ Sex: _____ DOB:_____ Age:_____

Medical Insurance Card Number: _____
Type of Medical Insurance: _____

Doctors Name & Telephone Number:
_____
_____

Previous Day Care Name: _____ Phone Number: _____

Parent/Guardian Information

Name First/Last: -
_____ DOB: _____

Relation to Child:_____
_____

Street Address:
_____
_____

Phone Number Home:
_____

Cellular Phone Number:

Work Phone Number:

Additional Contact Information Parent/Guardian:

Type of Care:

Full-Time or Part-Time

Pick Up List:

Name: _____
Phone Number: _____

Name: _____
Phone Number: _____

Name: _____
Phone Number: _____

Emergency Contacts:

Name: _____
Phone Number: _____

Name: _____
Phone Number: _____

Name: _____
Phone Number: _____

PLEASE COMPLETE ALL SECTIONS AND ENSURE THE CHILD'S NAME AND PREVIOUS DAYCARE FACILITY ARE ON INCLUDED ALONG WITH A COPY OF THE IMMUNIZATION RECORD IS TURNED IN WITH THIS FORM.