



**Pump-It-Up of Parker**  
18850 Clarke Road  
Parker, CO 80134-9062  
(720) 842-0200

## PARENT/GUARDIAN & CHILD INFORMATION SHEET

Date of Enrollment: \_\_\_\_\_ Date of 1 Yr Review: \_\_\_\_\_ Date of 2 Yr Review: \_\_\_\_\_ Date of 3 Yr Review: \_\_\_\_\_

### GENERAL INFORMATION

Parent/Guardian's Name (Last, First): \_\_\_\_\_ *Note: This parent(s) can pick up child anytime*

1<sup>st</sup> Child's Name & DOB: \_\_\_\_\_ 2<sup>nd</sup> Child's Name & DOB: \_\_\_\_\_

3<sup>rd</sup> Child's Name & DOB: \_\_\_\_\_ 4<sup>th</sup> Child's Name & DOB: \_\_\_\_\_

Main Home Phone #: \_\_\_\_\_ Main E-mail: \_\_\_\_\_

Main Home Street Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

#### MOTHER/GUARDIAN

#### FATHER/GUARDIAN

Place of Employment: \_\_\_\_\_  
Employment: \_\_\_\_\_

Place of  
Employment: \_\_\_\_\_

Work Address: \_\_\_\_\_

Work Address: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Pgr/Cell #: \_\_\_\_\_

Pgr/Cell #: \_\_\_\_\_

### PERSONS ALLOWED TO PICK UP & EMERGENCY CONTACTS

(other than a parent, must be in-town and able to assume responsibility if parents are unavailable)

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Cell/Pgr #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Cell/Pgr #: \_\_\_\_\_

Any persons picking up the above children must use the correct CODE WORD: \_\_\_\_\_

### MEDICAL & DENTAL INFORMATION

Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_ Address: \_\_\_\_\_

Hospital of Choice: \_\_\_\_\_ Phone #: \_\_\_\_\_ Address: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone #: \_\_\_\_\_ Address: \_\_\_\_\_

Insurance Carrier & Policy #: \_\_\_\_\_

Any medical/allergy conditions to be aware of? \_\_\_\_\_ Any dietary restrictions? \_\_\_\_\_

Any special needs or problems we should be aware of? \_\_\_\_\_

I give permission for my child/toddler to rest on a mat? YES NO I give permission for my child to watch a PG movie? YES NO

I GIVE MY CONSENT FOR THE ABOVE NAMED CHILD OR CHILDREN TO RECEIVE EMERGENCY MEDICAL OR DENTAL TREATMENT IN THE CARE OF A PHYSICIAN AND/OR HOSPITAL OR CLINIC. **AND** I HAVE RECEIVED THE CENTER'S POLICIES & PROCEDURES AND WILL REVIEW THEM THOROUGHLY SO THAT I MAY UNDERSTAND THE RIGHTS AND PROTECTION OF MY CHILDREN AND THE POLICIES, PROCEDURES AND RULES OF THE CENTER.

Signature of Parent/Guardian: \_\_\_\_\_