

Moonlight Basin Daycare Registration Package

Please complete one form per child

Email to daycare@moonlightbasin.com or fax to (406) 993 6694

Child's Full Name: Date of Birth:

Parent's/Guardian's Name: Telephone #:

Primary Address:

City: State: Zip Code:

Local Address:

City: State: Zip Code:

For each day of the reservation please provide the following information:

Date	Full or Half Day? (Circle One)	If Half Day, AM or PM? (Circle One)	Do you need a Ski Lesson on this day? (Circle One)	Please indicate Ski Lessons type, if required? One on One or Tenderfeet (Circle one)	Lesson Time AM or PM? (Circle One)
	Full / Half	AM / PM	Yes / No	One on One / Tenderfeet	AM / PM
	Full / Half	AM / PM	Yes / No	One on One / Tenderfeet	AM / PM
	Full / Half	AM / PM	Yes / No	One on One / Tenderfeet	AM / PM
	Full / Half	AM / PM	Yes / No	One on One / Tenderfeet	AM / PM
	Full / Half	AM / PM	Yes / No	One on One / Tenderfeet	AM / PM
	Full / Half	AM / PM	Yes / No	One on One / Tenderfeet	AM / PM
	Full / Half	AM / PM	Yes / No	One on One / Tenderfeet	AM / PM

NOTE: If Child is attending Ski Lessons, please be sure to complete the Trips section of the WRITTEN CONSENT IS GIVEN FOR: form. Please also be aware of the

PAYMENT INFORMATION

Visa/MasterCard Discover American Express Cash Check #:

Credit Card #: SSV #:

Expiration Date: Name on Card:

Billing Address:

Cardholder Signature: Date:

Tell Us About Your Child

Child's Name:

Has your child ever been in a daycare setting before? YES NO

Are there any special anxieties about daycare?

Please Explain:

Special communication needs/preferences (sign language, child's names for certain objects, etc):

Nourishment preference (check one): Breast Formula Combination N/A

How many bottles while at Daycare? _____ How many ounces per bottle? _____

Warmed up? YES NO

Solid Food? YES NO

My child can eat anything except:

Nap time is a very important part of my child's day. YES NO

My child usually naps at _____ (am/pm) for _____ hrs

*Please note if nap times are still adjusting to Mountain Time Zone:

My Child's favorite security items are:

My child is comforted by:

How does your child fall sleep asleep? (Rocking, holding, on own, story, music, etc.).....

Describe any current physical, mental, or psychological conditions that require any medication, treatment, or special restrictions/considerations while at Daycare.

List any illnesses your child has had in the past 24 hours:

My child's potty training can best be described as:

Completed Needs to be reminded Just beginning N/A

Suggestions on how we might assist your child in this area:

Emergency Contact and Parental Consent

THIS FORM MUST BE TAKEN WITH THE CHILD WHEN EMERGENCY MEDICAL CARE IS NEEDED

Child's Full Name: Date of Birth:

Primary Address:

City: State: Zip Code:

Mother / Legal Guardian's Name: Home #:

Primary Address: Cell #:

City: State: Zip Code: Work #:

Mother / Legal Guardian's Name: Home #:

Primary Address: Cell #:

City: State: Zip Code: Work #:

Emergency Contact Person: Contact #:

Emergency Contact Person: Contact #:

Physician / Medical Care Source: Contact #:

Health Insurance Carrier:

Policy Number:

Persons authorized to pick up child:

Name: Name:

Name: Name:

Written Consent Is Given For:

YES **NO** Emergency Medical Care

Administration of Prescription Medications

Medication Authorization form and Medication Administration Log must be completed.

Administration of Non - Prescription Medications

OTC Medication Authorization form and Medication Administration Log must be completed.

Administration of Special Dental or Dietary Needs
Please Specify:

Trips **YES** **NO** Transportation by the Facility for trips

YES **NO** Daily Transportation provided by the Facility (Facility has the option to offer)

If your Child is transported by the facility, are there any instructions for special care for the child (i.e. motion sickness, seizures, etc.) during transportation?

Health History

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Hay fever, asthma, or wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>
Eczema or frequent skin rashes	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Trouble with passing urine / Bowel movement	<input type="checkbox"/>	<input type="checkbox"/>
Heart condition	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds, sore throats, Earaches, tonsillitis, pneumonia	<input type="checkbox"/>	<input type="checkbox"/>

Allergies or reaction: (food or other) **YES** **NO**
Please Explain:

Other Health Concerns (special disabilities): **YES** **NO**
Please Explain:

.....
SIGNATURE OF PARENT OR GUARDIAN

DATE