TICK TOCK AROUND THE CLOCK
REGISTRATION FORM

918 Big Bethel Road • Hampton VA 23666 • Phone: (757) 224-3758 • FAX (757) 224-3879

CHILD'S INFORMATION

Child's Name: _____ Sex: _____ DOB: _____ Grade: _____
Last Name First M. I. mm/dd/yy

Birth State of Child: _____ Birth Certificate #: _____

STUDENT'S ADDRESS

_____ (____)_____
Street City State Zip Phone

SCHOOL/CENTER'S INFORMATION:

Name of Child's School/Center: _____

School/Center's Drop off time & Location: _____ a.m. _____

School/Center's Pick up time & Location: _____ p.m. _____

Teacher/Contact Person's Name: _____Room: _____

FATHER/GUARDIAN INFORMATION:

Name: _____ Employer: _____

Driver License or SSN Number: _____ Work Phone: _____

Cell Number: _____ Lives with Child: Yes _____ No _____

Email Address: _____

MOTHER/GUARDIAN INFORMATION:

Name: _____ Employer: _____

Driver License or SSN Number: _____ Work Phone: _____

Cell Number: _____ Lives with Child: Yes _____ No _____

Email Address: _____

Choose Program: *(check one)*

☐ Before School Care ($160 monthly)	☐ After School Care ($270 monthly)
☐ Evening Childcare ($325/$450 monthly)	☐ Before & After School Care ($325 monthly)
☐ Early Learners Program w/childcare ($470 monthly)	☐ Early Learners Program ($325 monthly)
☐ Young Achievers Program w/childcare ($520 monthly	☐ Young Achievers Program ($395 monthly

Please list three responsible relatives or individuals who may be contacted in an emergency and is authorized to pick up your child.

	Name	Phone Number	Relation
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

TRANSPORTATION INFORMATION

Please list all persons authorized to pick-up your child:

	Name	Phone Number	Relation
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

CHILD'S HEALTH AND SOCIAL INFORMATION

Please provide information relative to the general health of your child.

1. Is your child on a special or restricted diet or have any food allergies? Yes _____ No _____
   If yes, please explain.

   _____

   _____

   _____

2. Does your child currently take any medications that may alter his/her behavior? Yes _____ No _____
   (i.e. Albuterol, Ritalin, etc.) If yes, please explain.

   _____

   _____

   _____

3. Does your child have physical limitations? Yes _____ No _____
   If yes, please explain.

   _____

   _____

   _____

4. Can your child effectively communicate his or her needs? Yes _____ No _____
   If no, please explain.

   _____

   _____

   _____

5. Has your child ever been in a childcare setting? Yes _____ No _____
   If yes, what kind?

   _____

   _____

   _____

6. Does your child have an existing condition of which we should be aware? Yes _____ No _____
   If yes, please explain.

   _____

   _____

   _____

7. Does your child require any medication, therapy, medical treatment, or assessment while in the program? **IF YES, YOU WILL BE RESPONSIBLE FOR ADMINISTERING MEDICATION.** Yes _____ No _____

8. Does your child have any problem at mealtime? Yes _____ No _____
   If yes, please explain.

   _____

   _____

   _____

9. Is your child toilet trained? Yes _____ No _____

10. Does your child use special equipment, such as a breathing machine, hearing aid, braces, etc.? Yes _____ No _____
    If yes, please explain

    _____

    _____

    _____

MEDICAL PROVIDERS

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Preferred Hospital: _____

Health Insurance Carrier: _____ Policy # _____

Policy Holder: _____ Relation _____

PARENTAL CONSENT FOR TREATMENT

Do we have permission to give any medical treatment necessary to your child in case we are unable to contact you? Yes _____ No _____
Any exceptions? If yes, please specify:

_____

_____

The Parent/Guardian will be responsible for picking up an ill child immediately upon notification from the staff.

I/We the undersigned, do hereby authorize that the certified medical center/hospital is given the authority to render necessary medical services to my/our child which results, directly or indirectly, from his/her participation in trips, programs or activities by Tick…Tock…Around the Clock and I/we, the undersigned; also hereby agree to be responsible for such charges made by medical center/hospital, doctor, ambulance, etc., in providing such medical services as are referred to above.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

ASSUMPTION OF RESPONSIBILTY/FIELD TRIP PERMISSION

for_____
(*Child's name*)

I am aware of the general nature of the Field Trip program sponsored by Tick…Tock…Around the Clock and I agree to hold harmless Tick…Tock…Around the Clock, as well as, its employees/staff from any loss, damage, claim, demand, liability, or expense occurred as a result of any damage to property or person, caused by my child while participating in the program. I declare to best of my knowledge and belief that my child is in sufficiently good health and physical condition to participate in the program.

By signing below, I/We certify that the information submitted is correct. Understanding all the enclosed information, I/We pledge to give my/our support and cooperation to Tick…Tock…Around the Clock and agrees to comply with all policies of the Program Director. I understand that TTAC has the right to deny enrollment if inaccurate information has been submitted.

_____ _____
Father/Legal Guardian's Signature Mother/Legal Guardian's Signature

_____ _____
Date Date