



DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF

EDUCATION

REGISTRATION RECORD FOR CHILD RECEIVING CARE AWAY FROM HOME

Child: _____ Sex: Male Female
Last First M.I.
Date of Birth: _____ Home #: _____ Language Spoken At Home _____
Home Address: _____
Number Street Apt. # State ZIP

Parent: _____ Home # _____
Last First M.I. Business # _____
Home Address: _____
Number Street Apt. # State ZIP
Business Address: _____
Number Street Apt. # State ZIP

Parent: _____ 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 (other than parent/guardian):
_____ 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:** _____