



CIPRIANI PLACE
4 Cipriani Boulevard
Port of Spain
familycourt@ttlawcourts.org
Tel: (868) 624-4405 / 627-6297

CHILDREN'S WAITING ROOM REGISTRATION FORM.

Case Number _____

Section A

1. Child's Full Name: _____ 2. Birth Date: _____
First Middle Surname (dd / mm / yy)

3. Age _____ 4. Sex _____

5. Child's Full Name: _____ 6. Birth Date: _____
First Middle Surname (dd / mm / yy)

7. Age _____ 8. Sex _____

9. Child's Full Name: _____ 10. Birth Date: _____
First Middle Surname (dd / mm / yy)

11. Age _____ 12. Sex _____

13. Child's Full Name: _____ 14. Birth Date: _____
First Middle Surname (dd / mm / yy)

15. Age _____ 16. Sex _____

17. Address: _____

18. Home Phone: _____

19. Nationality _____

20. Nickname: _____

Date_____

Signature of Parent/guardian

Signature of Day Care Officer

Date_____

Emergency Information

Primary Emergency Contact (other than parents or guardian) _____

Home Phone: _____ Work Phone: _____

Relationship to Child: _____

Address: _____

Medical Information

1. Child's Physician: _____ Phone: _____

2. Is your child currently on any medications: () yes () no

a. If yes state the name of medication/s _____

b. What is the purpose of the medication _____

3. Any Allergies: _____

4. Any special health conditions: _____

Emergency Release

Consent to Emergency First Aid & Transportation:

I hereby give permission that my child, _____, may be given minor first aide treatment by a staff member at Family Court Children's Waiting Room. I also give permission for my child to be transported to an emergency center for treatment, and understand and agree that the Family Court and its employees will not be held accountable.

Parent's Signature _____ Date: _____

I understand this is a legally binding contract, and I have read it and understand it.