CHILD'S APPLICATION FOR ENROLLMENT

To be completed, signed, and placed on file in the facility on the first day and updated as changes occur and at least annually.

Date Application completed or updated: _____ Date of enrollment: _____

CHILD INFORMATION

Full Name: _____ DOB _____

(Last) (First) (MI) (Nickname)

Address: _____Zip Code_____

What days is your child going to attend: (select 5-3-2 days)

Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐

FAMILY INFORMATION Child Lives with: _____

Parent/Guardian _____ Home Phone _____ Cell Phone: _____

Address (if different from child's) _____

Where Employed _____ Can we reach you at work: Y N Work Phone _____

Email Address _____

Parent/Guardian _____ Home Phone _____ Cell Phone: _____

Address _____ Zip Code _____

Where Employed _____ Can we reach you at work: Y N Work Phone _____

Email Address _____

Contacts: Child will be released only to the parents/guardians listed above. The child can also be released to the following individuals, as authorized by the person who signs this application. In the event of an emergency, if the parents/guardians cannot be reached, the facility has permission to contact the following individuals.

Name	Relationship	Address	Phone Number
_____			
Name	Relationship	Address	Phone Number
_____			
Name	Relationship	Address	Phone Number
_____			

Health Care Needs: For any child with health care needs such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child's parent or health care professional. Is there a medical action plan attached? Yes __ No __(Medical action plan must be update on an annual bas

List any allergies and the symptoms and type of response required for allergic reactions:

_____

_____

List any health needs or concerns, symptoms of any type of response for these health care needs or concerns: _____

_____

List any particular fears or unique behavior characteristics the child has: _____

_____

_____

List any types of medication taken for health care needs_____

_____

Share any other information that has a direct bearing on assuring safe medical treatment for your child: _____

EMERGENCY MEDICAL CARE INFORMATION

Name of health care professional _____Office phone _____

Hospital preference _____ Phone _____

I, as the parent/guardian, authorize the center to obtain medical attention for my child in an emergency and to use appropriate physician of his/her choice to provide emergency care if neither I, nor the family physician can be contacted immediately.

Signature of parent/guardian: _____ Date: _____

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of an emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or any medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian.

_____

Signature of Operator Date