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: Date of Enrollment:

**CHILD INFORMATION:** Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name:

Last

First Middle Nickname

Child’s Physical Address:

**FAMILY INFORMATION**: Child lives with:

Father/Guardian’s Name Home Phone Address (if different from Zip Code child’s) Work Phone Cell Phone

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother/Guardian’s Name Home Phone Address (if different from Zip Code child’s) Work Phone Cell 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 updated on an annual basis and when changes to the plan occur)*

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

List any health care needs or concerns, symptoms of and 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.

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 Administrator Date

Revised 08282021