Date Application Completed_____ Date of Enrollment_____

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.

CHILD INFORMATION:

Full Name: _____ Date of Birth: _____
Last First Middle Nickname

Child's Physical Address:_____
Street City State Zip

FAMILY INFORMATION:

Father/Guardian's Name _____ Cell Phone _____
Address (if different from child's) _____ Zip Code _____
Email _____ Other Phone _____

Mother/Guardian's Name _____ Cell Phone _____
Address (if different from child's) _____ Zip Code _____
Email _____ Other Phone _____

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___

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 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_____