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:** 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 child's) _____ Zip Code _____ Work Phone _____

Cell Phone_____

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

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**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_____