Date Application Completed: _____ Date of Enrollment: _____ E- Mail _____

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: _____ Cell Phone: _____

Address (if different from child's) _____ Zip Code: _____

Place of Employment: _____ Work Phone: _____

Mother/Guardian's Name: _____ Home Phone _____ Cell Phone: _____

Address (if different from child's) : _____ Zip Code _____

Place of Employment: _____ Work 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 __ (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: _____ Office 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: _____