

**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:** Please list the names of individuals to whom the center may release the child, as authorized by the person who signs the application. The operator, administrator, and staff shall release a child only to an individual(s) listed on the application.

**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 chronic illness the individual has and any medication taken for that illness \_\_\_\_\_

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

**EMERGENCY MEDICAL CARE INFORMATION:**

Emergency medical care information must be on file for each individual child. This information must include the name, address, and telephone number of the parent or other person to be contacted in case of an emergency.

Name	Address	Phone Number
Name	Address	Phone Number

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, 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 \_\_\_\_\_