



Child's Application

Application Date _____
Date of Enrollment _____

To be completed, signed, and placed in the facility on the first day and updated as changes occur and at least annually.

Name of Child _____ Age _____ Birth date _____
(Last) (First) (MI) Nickname

Address _____ Zip Code _____

INFORMATION ABOUT THE FAMILY:

Child lives with _____

Father/Guardian's Name _____ Home Phone _____

Address _____ Zip Code _____

Where Employed _____ Business Phone Number _____

Email _____ Cell Phone Number _____

Mother/Guardian's Name _____ Home Phone _____

Address _____ Zip Code _____

Where Employed _____ Business Phone Number _____

Email _____ Cell Phone Number _____

INFORMATION ABOUT YOUR CHILD: Is there a medical action plan attached? _____

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

Please give any information concerning your child which will be helpful in his/her experience in group setting (such as playing, eating, and sleeping habits, unique behavior, special fears, special likes or dislikes).

List any health care needs or concerns, symptoms of and type of response for these health care needs or concerns.

List any type of medication taken for health care needs _____

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

Attach a medical action plan for any child with health care needs that has been completed by the child's doctor or parent.

EMERGENCY CARE INFORMATION:

Name of Child's Doctor _____ Office Phone _____

Hospital Preference _____ Office Phone _____

Insurance Carrier _____ Policy # _____

Child will be released only to parent/guardian above and the following individuals. (Please list relationship)

Name _____ Address _____ Phone Number _____

Name _____ Address _____ Phone Number _____

Name _____ Address _____ Phone Number _____

In the event of an emergency, if the parents/guardian cannot be contacted, contact the following. (Please list relationship)

Name _____ Address _____ Phone Number _____

Name _____ Address _____ Phone Number _____

I, as the parent/guardian, agree the operator may authorize the physician of his/her choice to provide emergency care in the event that neither I nor the family physician can be contacted immediately. All the information is true and authorized by person who signs this application.

Parent Signature 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. Provisions will be made for adequate and appropriate rest and outdoor play.

Operator Signature Date