Children's Campus
First Steps to a Lifetime of Learning

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:

_____

F AMILY 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.

_____

_____

Key Scan 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? Check Yes___No___ If yes, please List any allergies and the symptoms and type of response required for allergic reactions. _____

_____

Does your child have any health care needs or concerns? Check Yes ___ No ____If yes, please explain symptoms of and type of response for these health care needs or concerns.

_____

Does your child have any particular fears or unique behaviors or characteristics? Check Yes ___ No ____If yes, please explain_____

_____

Does your child have any chronic illness? Check Yes ___ No ____ If yes, list any medication taken for that illness_____

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

Child, if nothing to share, **write N/A.**_____

_____

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_____