Date Application Completed: __________

School Location: _________________

Application for Enrollment

Program:

☐ Infant ☐ Toddler ☐ Young Preschool ☐ Pre-School ☐ Pre-K Academy ☐ School-Age ☐ Other__________

Typical hours of attendance: _______________ A.M. to __________________ P.M.

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Full Day ☐ Half Day

Meals normally eaten at the center: ☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack

Personal Information:

Full Name of Child: ____ Date of Admission: _________________________

Child's Physical Address: ____ Child lives with: _________________________

Child's DOB: _________________ Name the child goes by: _____________________________________ ☐ Male ☐ Female

Is the child related to the primary caregiver? ☐ No ☐ Yes – Relationship: ____

Child's school (if applicable): ____

Name Address Phone

Are the child's immunization records housed at the above school: ☐ Yes ☐ No If no, list the school where they are housed: ____

Name Address Phone

Parents/Custodial Parents:

Mother's Name: ___________________________________

S.S. #____________________ D.L. # ________________

Home Address: __________________________________

____

City State Zip

Email Address: __________________________________

Home Phone: ____________________________________

Cell Phone: _____________________________________

Employment: ____________________________________

Work Address: ________________________________

____

City State Zip

Work Phone: ____________________________________

Work Hours: _____________________________________

Father's Name:____

S.S. # ____________________ D.L. # ____________________

Home Address: ______________________________________

____

City State Zip

Email Address: ______________________________________

Home Phone: ____

Cell Phone: ____

Employment: ____

Work Address: ____

____

City State Zip

Work Phone: _______________________________________

Work Hours: ____

Transportation Plan:

Please list any other adults to whom your child may be released or are authorized to provide transportation for your child: ____

____

Will your child be transported by us? ☐ No ☐ Yes
If yes, check all that apply: ☐ to school ☐ from school ☐ field trips only - with prior written permission for each off-site activity

Emergency Contact Information:

1. Name of person, other than the child care provider, authorized to act for parent in an emergency.

______________________ Relationship to child: ______________________

Home Address: ______________________ Home Phone: ______________________
City State Zip

Place & Address
of Employment/School: ______________________
City State Zip

Work Phone: ______________________ Work Hours: ______________________

Alternate Phone Numbers (cell): ______________________

2. Name of person, other than the child care provider, authorized to act for parent in an emergency.

______________________ Relationship to child: ______________________

Home Address: ______________________ Home Phone: ______________________
City State Zip

Place & Address
of Employment/School: ______________________
City State Zip

Work Phone: ______________________ Work Hours: ______________________

Alternate Phone Numbers (cell): ______________________

Authorized Alternative Pick Up Contacts:

1. Name: ______________________
Relationship to child: ______________________
Home Address: ______________________
____
City State Zip
Home Phone: ______________________
Work Phone: ______________________
Cell Phone: ______________________

2. Name: ______________________
Relationship to child: ______________________
Home Address: ______________________
____
City State Zip
Home Phone: ______________________
Work Phone: ______________________
Cell Phone: ______________________

Physician Contact Information:

Name of Physician: ______________________ Phone: ______________________

Address: ______________________
City State Zip

Name of Dentist: ______________________ Phone: ______________________

Address: ______________________
City State Zip

Hospital Preference Information:

Hospital Name: ____ Phone: ______________________________

Address: ____
City State Zip

EMERGENCY MEDICAL AUTHORIZATION

In the event of an emergency, I give the center permission to obtain medical transport/ assistance for my child, ________________________, to ________________________ hospital or to the nearest available source of assistance for emergency medical care.

Parent Signature: ___________________________________ Date: ____________________________

Background Information:

Other Children in the Family	Date of Birth	School

Experiences with Others:

What are some of the ways your child plays at home? ____

Does he/she play with children from other families? ______ How? ____

How does he/she react when he/she does not “get his/her way?” ____
____

Is the entire family together for any time during the day? ____

Eating Habits:

At what time does the child eat breakfast? _____________ Lunch? _____________ Dinner? _____________
Between-meal Snacks? ________ Does the child feed himself/herself? ____
What is the child’s general attitude toward eating? ____
If the child refuses to eat, how is this handled and by whom? ____
____
____
Food Favorites: ____
Food Dislikes: ____
Food Allergies: ____
If your child is an infant, use a separate sheet for information about the formula, bottle schedule, etc.

Sleep Habits:

Has own room: _______ Shares room with: ☐ Other Children ☐ Parents
At night sleeps from ___________ to ___________ Average Hours of Sleep per Night: ___________________________
Naps from __________ to ___________ Average Hours of Naps: ____
Attitude toward going to bed: ____
If there is difficulty, how is this handled? ____
Habits associated with going to bed? ____
Is bed wetting an issue? ______________________________ At nap time? __________ At night? __________
If yes, how is the situation handled? ____

Toilet Habits:

Time at which your child is taken to the bathroom?
____
Can your child take themself? ______________ Time of bowel movement? ____________ Regular? _____________
Constipated? _____________ Does your child tell you when he/she needs to go and does he/she go willingly? ________
Can he/she manage his/her clothes at the toilet? _____________________ What words does he/she use for:
Urinating: ____ BM: ____

Speech and Physical Growth:

Your child talks: ☐ Well ☐ Fairly Well ☐ Not Very Well ☐ Not at All
Does anyone read to your child? _______ How regularly? _______________
At what age did your child become mobile? ________________ Crawl? _______________ Walk? __________________
Which of the following words would you use to describe your child (check all that apply):
☐ active ☐ quiet ☐ thin ☐ average weight ☐ heavy ☐ tall ☐ average height ☐ short ☐ friendly ☐ unfriendly

Description of child's comforting habits and methods (for Infant/Toddler age child):
____
____
____

Is there any other information you think we should have about your child (including any particular fears)?
____
____
____
____
____

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 or and type of response for these health care needs or concerns:
____
____
List any chronic illness the child has and any medication taken for that illness: _______________________________
____
Does your child have any medical diagnosis that requires ongoing care? ☐ Yes ☐ No
Are you requesting that this care be provided at the facility? ☐ Yes ☐ No
If yes, describe the care required: ____
____
(Request a doctor's statement for any specified request for care and ensure a Special Needs Application is completed).

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

How Did You Hear About Us?

We try our best to inform people in the community about our quality program. Your input would be most helpful.
How did you hear about us?

________ Website ________ Flyer _______ Drive by Sign

________ Direct Mail ________ Web Advertising _______ Referral from __________________________

________ Publication/Ad ________ Community Event

Parent Declarations:

I was provided a summary of licensing requirements and I was made aware of where I may locate them within the center.

I do hereby authorize emergency medical care for my child (a limited power of attorney may be required for military dependents).

I visited the center prior to enrolling my child. Pre-enrollment Visit Date: ______________________

I received a copy of the center's Family Handbook and the financial policies outlined on the Enrollment Financial Agreement and I have signed verifying by receipt my understanding and agreement of its content.

I authorize ________________________to transport my child as specified in the transportation plan section (see page 1).

____ ___________________________________

Signature of Parent(s)/Guardian(s) Date

I, as the operator, do agree to ensure 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 Program Director Date

===

FOR OFFICE USE

Information on this form must be updated annually or as needed to ensure the safety of the child.

Date of Review	**Parent's Signature**

This form must be retained for one year after the child's withdrawal date.

Child's Withdrawal Date: ____

Reason for Withdrawal: ____