Child Application

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's Application for Enrollment

Date Application Completed: _____ Date of Enrollment: _____

Name *

First Name Middle Name Last Name Suffix

Date of Birth

Month Day Year

Languages spoken at home

Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Insurance Carrier

Policy #

Family Information

Father/Guardian's Name

First Name Last Name

Address (if different from child's)

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Employer

Work Phone

Area Code Phone Number

Home Phone Number

Area Code Phone Number

Cell Phone Number *

Area Code Phone Number

Email *

Mother/Guardian's Name

First Name Last Name

Address (if different from child's)

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Employer

Work Phone Number

Area Code Phone Number

Home Phone Number

Area Code Phone Number

Cell Phone Number *

Area Code Phone Number

Email *

example@example.com

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.

Contact 1 Name

First Name Last Name

Relationship

Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Phone Number

Area Code Phone Number

Contact 2 Name

First Name Last Name

Relationship

Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Phone Number

Area Code

Phone Number

Contact 3 Name

First Name

Last Name

Relationship

Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Phone Number

Area Code

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?

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 Information

Name of Healthcare Professional

First Name Last Name

Office Phone

Area Code Phone Number

Hospital Preference

Phone Number

Area Code Phone Number

Do you know someone who may benefit from our services?

Please enter their information below.

Name

First Name Last Name

Email

Name

First Name Last Name

Email

example@example.com

Paypal Smart Buttons