**Divine Treasures Child Care Center**

7567 Haverford Ave. Philadelphia, PA 19151 7575 Haverford Ave. Philadelphia, PA 19151 1201 E Chelten Ave. Philadelphia, PA 19138 215-220-1197 215-220-1197 215-549-4760

**ENROLLMENT APPLICATION**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person Completing form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had any serious illnesses that may have required hospitalization?

Check One: Yes \_\_\_\_\_ No \_\_\_\_

If yes, what is the illness? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long was the hospitalization? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any special needs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any chronic health problems? (Check all that apply)

Allergies? If yes, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coughs \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ear Infections \_\_\_\_\_\_\_\_\_\_

Nosebleeds \_\_\_\_\_\_\_\_\_\_\_

Diarrhea \_\_\_\_\_\_\_\_\_\_\_\_\_\_

What communicable disease has your child had? (Check if applicable)

Measles \_\_\_\_\_\_\_\_\_\_ If, yes when? \_\_\_\_\_\_\_\_

Mumps \_\_\_\_\_\_\_\_\_\_\_ If yes, when? \_\_\_\_\_\_\_\_

Chicken Pox \_\_\_\_\_\_\_ If yes, when? \_\_\_\_\_\_\_\_

German Measles \_\_\_\_\_\_\_ If yes, when? \_\_\_\_\_\_\_\_

Scarlet Fever \_\_\_\_\_\_\_\_\_\_ If yes, when? \_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_