AG Academy

Enrollment Application Form

(608)556-5898
1001 Arboretum Drive
Waunakee Wi 53597

Please be advised, applications are per person not per family. Incomplete applications may be disqualified automatically. Incomplete, false or misleading application will be denied.

Today's Date_____
Childs full Legal name _____Nickname_____
Child's date of birth_____Child's age_____Social security number ____-_____-_____
Gender:

- ☐ Female
- ☐ Male

Ethnicity _____ Race _____
Primary language spoken at home _____
Primary language spoken by child _____
Address_____

Race is defined as a category of humankind that share certain distinctive physical traits

Ethnicity is defined as a large group of people classed according to common racial national, tribal, religious, linguistic, or cultural background.

Contact Info:

Parent/Guardian Name _____ Primary language _____
First and last

Mother Name _____ Primary Language _____
(Mother)Home Phone _____Work _____
Employment address _____Email _____
Father Name_____ Primary Language _____
Home Phone Number (_____) _____ Work_____
Employment address _____ Email _____
How do you prefer to be contacted (please circle) Call Cell Call Home Email Text

Emergency Contact Person_____(relationship to child)_____
Contact's phone_____
Emergency Contact Person_____(relationship to child)_____
Contact's phone_____
child lives with: (Please circle) Both parents One parent Mother/ Father Guardian (please specify_____)
Please let us know how you heard about us _____

What days and times do you need care?

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
☐ Am ☐ Pm ☐ Night	☐ Am ☐ Pm ☐ Night	☐ Am ☐ Pm ☐ Night	☐ Am ☐ Pm ☐ Night	☐ Am ☐ Pm ☐ Night	☐ Am ☐ Pm ☐ Night

Service Info:

Beginning date needing care_____ Until if applicable _____
drop off time _____ am/pm **pick-up** time _____ am/pm

Transportation: Parent pickup Center transport Walk (please complete additional forms)

Your Child's Health

CHILD'S HEALTH RECORD: (A copy of your child's immunizations and current health history report will be needed)
General state of health:
_____
_____
Doctor's name_____
Doctor's phone number_____
Dentists' name _____
Are your child's immunizations up to date? _____ (Please attach a copy of immunizations.
Was your child a full-term baby Yes ■ No ■

Disabilities

Does your child have any suspected disabilities including learning disabilities? Yes ■ No ■ Please explain
_____
Diagnosed _____ Suspected _____ currently on birth-3 or IEP_____
Does Your child require any special services? Yes ■ No ■ Please explain _____
Does anyone in the immediate family have any disabilities? _____
Does your now or in the future require special services from public health officials? Yes ■ No ■ Please explain_____
Does your child have any known **allergies?** _____
Are you concerned that your child may be prone to any type of allergies?_____
Describe:
_____
_____

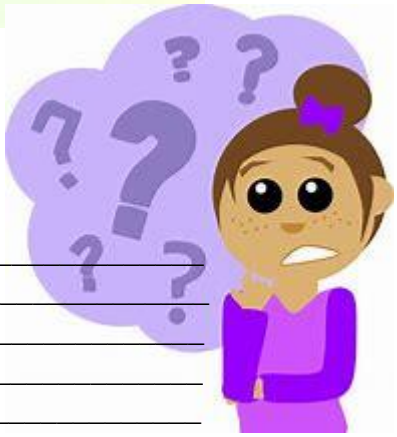
Does your child have any medical conditions which we should be made aware of to better provide for them?
_____

Has your child **had or currently have the following**? (*Please circle*)
Does your child have any problems with any of these? Has your child had any of these diseases?

Tuberculosis	Whooping Cough	Chicken Pox	Bronchitis	Urinary Problem
Constipation	Food allergies	Scarlet Fever Any recurring Fever	Frequent Ear Infections	R.L. S
Asthma	Skin Rash	Fainting Spells	Hepatitis	Covid-19
Convulsions	Diabetes	Frequent Diarrhea	Heart Disease	Frequent Colds
Impetigo Lice Any Lice	Sleep apnea	Pink eye	Stomach Upsets	Measles Mumps
Soiling Polio	Ringworm	Frequent Sore Throats	German Measles	Frequent nose bleeds
Fetal Alcohol Syndrome	N.E.C	Sleep walking	Seasonal allergies	Seizures
IEP	Birth to 3	Speech therapy	Hearing or visually impaired	Behavior issues

If you circled any of the above illnesses or conditions, please give any helpful information.
_____
_____

If you circled Covid-19 please provide the date of expose, any symptoms experienced leading up to and while having covid-19 _____



About Your Child

Please complete what is applicable to your child.

Has your child ever been in childcare before? _____
Was the previous childcare experience positive? _____
What type (center, family daycare, grandma etc.) _____
What are your long-term goals for your child's education? _____
Why are you looking for childcare? _____

Any recent trauma such as a death in the family, divorce, new sibling etc.? _____

What is your normal method of discipline? _____
What is your child's temperament? Are they easy going, hard to please, demanding, aggressive, etc.

_____

What is your child's favorite food? _____

What food does your child dislike? _____

Is your child potty trained _____

What words does your child use for: Bowel movements _____ urination_____

What time does your child awaken? _____

What time does your child go to sleep at night? _____

Do they sleep through the night? _____

Does your child sleep in a bed or crib, other? _____

Do they have siblings? Please name them and specify ages and gender.

Name _____ age _____ gender _____

Name _____ age _____ gender _____

Name _____ age _____ gender _____

Is there a preferred language you would like your child to learn?

1. _____
2. _____
3. _____

Does your child have any security objects such as a blanket, soother, bottle, toy etc.?

_____

What are your child's favorite activities, toys, books, or games? _____

Any additional Information you would like to include.

_____

_____

_____

_____

_____

_____

_____

_____