

**Childrens Corner Child Development Center**

4750 42<sup>nd</sup> St Ne, CR, IA 52411  
Phone: 319-393-8383

Director: Mary Ronnenberg

Enrollment Date: \_\_\_\_\_  
Registration Fee: \_\_\_\_\_

**Enrollment Application**

Child's name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

Parents' Names(s): \_\_\_\_\_

Alt Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Email address (for cancellation notifications): \_\_\_\_\_

**Family History**

Marital Status: Single\_\_\_ Married\_\_\_ Divorced\_\_\_ Separated\_\_\_ Deceased\_\_\_

Other Children in Home: \_\_\_\_\_ Age: \_\_\_\_\_

\_\_\_\_\_ Age: \_\_\_\_\_

\_\_\_\_\_ Age: \_\_\_\_\_

**Physical Regimen**

Any food allergies or medical problems that we need to be aware of? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Play/Socialization**

Previous group experience?: \_\_\_\_\_

**Personality and Emotional Development**

Affectionate? \_\_\_\_\_ Fears? \_\_\_\_\_

Accepts me people easily? \_\_\_\_\_ Usually Happy? \_\_\_\_\_

Any nervous habits? \_\_\_\_\_

How does s/he react to change in routine? \_\_\_\_\_

\_\_\_\_\_

Please give any other information that you believe will be of help to us in understanding your child: \_\_\_\_\_

\_\_\_\_\_

**Explain why you have chosen a group day care setting for your child:**

State Licensing standards \_\_\_\_\_

Educational opportunities \_\_\_\_\_

Food Program(s) \_\_\_\_\_

Availability of Substitute Caregivers \_\_\_\_\_

Other: \_\_\_\_\_

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**Travel and Activity Authorization**

I give permission for my child, \_\_\_\_\_ to leave the center for trips in a car or on public transportation to special places, walks, to the park, field trips, etc. I understand that my child will ride only in vehicles that provide approved seat belt protection and that s/he will not be riding in the front seat of such a vehicle.

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

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**Picture Release**

I hereby give my consent to let my child be photographed for use by the center to be used in newspapers and/or other media

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

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**Pick-Up Permission**

I hereby give permission for my child to leave the center with the following persons due to illness or transportation problems,. I will notify the center IN ADVANCE whenever any of these persons intend to pick up my child. I will also notify the center of any changes in this roster.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

\*Name any person who MAY NOT pick up your child: \_\_\_\_\_

\*\* Please note that in case of divorce or separation, we must have a court document on file explaining visitation/custody rights. Thank you.

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

## Parental Emergency Medical Consent

This form must be presented upon admission for treatment. Consent will be effective one year from date of signature.

**Child's full name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

This form allows parents and guardians to authorize the provision of emergency treatment for above named child who becomes ill or injured while under program authority when parents or guardians cannot be reached. In the event reasonable attempts to contact me at \_\_\_\_\_ (Phone number) or \_\_\_\_\_ (Phone number) have been unsuccessful, I hereby give consent to the administration of any treatment deemed necessary by:

**Doctor (Physician):** \_\_\_\_\_ **Doctor (Dentist):** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Or in the event the designated practitioners are not available, then by another licensed physician or dentist and/or the transfer of the child to \_\_\_\_\_ (Preferred hospital).

### Parent/Guardian with whom the child resides:

**\*Name:** \_\_\_\_\_ **Relationship to Child:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_ **Cell:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_ **Work Hours:** \_\_\_\_\_

**\*Name:** \_\_\_\_\_ **Relationship to Child:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_ **Cell:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_ **Work Hours:** \_\_\_\_\_

### Emergency Contacts:

**\*Name:** \_\_\_\_\_ **Relationship to Child:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work:** \_\_\_\_\_ **Cell:** \_\_\_\_\_

**\*Name:** \_\_\_\_\_ **Relationship to Child:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work:** \_\_\_\_\_ **Cell:** \_\_\_\_\_

**Date of Last Tetanus:** \_\_\_\_\_ **Known Allergies:** \_\_\_\_\_

**Current Medication:** \_\_\_\_\_

**Current Insurance:** \_\_\_\_\_ **Policy Holder's I.D.** \_\_\_\_\_

**Signature/Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature/Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_