CHILD'S APPLICATION FOR ENROLLMENT

Date Application Completed _______________ Part Time or Full- Time (Please Circle) M T W TH F
Date of Enrollment ______________________

SCHOOL: (Please Circle One) Hillsborough- Davis Rd. Hillsborough- Meadowlands Dr. Cary- High House Cary- Carpenter Village

CHILD INFORMATION: Date of Birth:____________________

Full Name:____ Nickname:___________________

Child's Physical address:____

FAMILY INFORMATION: Child lives with: ____
Mother/Parent/Guardian's Name _______________________________Occupation:_______________________________
Address (if different from chid's) ____
Cell Phone____ Work Phone ____
Email: ____ Home Phone ____

Father/Parent/Guardian's Name _______________________________Occupation:_______________________________
Address (if different from chid's) ____
Cell Phone____ Work Phone ____
Email: ____ Home Phone ____

CONTACTS: Child will be released only to the parents/guardians listed above and the following individuals listed below, 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. (Please list two alternate contacts other than parents/guardians.)

____
Name Relationship Address Phone Number

____
Name Relationship Address 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? Yes________ No________
List any allergies and the symptoms and type of response required for allergic reactions.____________________________
List any dietary restrictions ____
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 chronic illness the individual has and 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 CARE INFORMATION:
Name of health care professional _____________________________________ Office Phone _________________________
Hospital preference ____ Phone ____________________________

I, as the parent/guardian, authorize the center to obtain medical attention for my child in an emergency.

Signature of Parent/Guardian____ Date___________________________

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of an 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 instruction from the physician or the child's parent, guardian, or full-time custodian.

Signature of Administrator____ Date___________________________