



Application Date _____ **Child's Enrollment Application** Date of Enrollment _____

Child Information

Date of Birth _____

Child's Name _____
Last First Middle Called by
Address _____

Family Information

Child lives with _____

Parent/Guardian's Name _____ Relationship _____ Home Phone _____
Address (if different from child) _____ Cell Phone _____
Driver's License _____ Employer _____ Work Phone _____

Parent/Guardian's Name _____ Relationship _____ Home Phone _____
Address (if different from child) _____ Cell Phone _____
Driver's License _____ Employer _____ Work Phone _____

Custody papers to be considered. Yes ___ No ___ if yes, please explain _____

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.

Name _____ Relationship _____ Address _____ Home Phone _____ Cell Phone _____
Name _____ Relationship _____ Address _____ Home Phone _____ Cell Phone _____
Name _____ Relationship _____ Address _____ Home Phone _____ Cell Phone _____

In the event of an emergency, if the parents/guardians cannot be reached, the facility has permission to contact the following individuals.

Name _____ Relationship _____ Address _____ Home Phone _____ Cell Phone _____
Name _____ Relationship _____ Address _____ Home Phone _____ Cell Phone _____

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, the symptoms and type of response required for allergic reactions: _____

List any health care needs or concerns, symptoms of and type of response for them _____

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 Care Information:

Name of health care professional _____ Office Phone _____
Hospital Preference _____ Phone _____

Medical Authorization

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

Parent/Guardian's Signature _____ Date _____

I, _____ as the operator, do agree to provide transportation to an appropriate medical resource in the event of emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or any medication without specific instructions from the physician or the child's parent guardian, or full-time custodian.

Director's Signature _____ Date _____

Photograph Authorization

We like to display pictures on bulletin boards and in albums to show perspective enrollees the children engaged in activities. Please indicate if photographs in which your child is pictured may be used.

____ Yes, I consent to photographs of my child being posted on bulletin boards and in school albums.
____ No, I do not wish photographs of my child being posted on bulletin boards or in school albums.

We like to use photos of children enrolled in our school on the ABG's web site and Face Book page. Please indicate if your child may be photographed and the picture used on the ABG's web site and Face Book page.

____ Yes, I consent to my child's photo being used on the ABG's web site and Face Book page.
____ No, I do not wish for my child's photo to be used on the ABG's web site and Face Book page.



Date of Enrollment	Date of Withdrawal
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Child's Care and Emergency Information

Name of Child (Last, First Middle Initial)		Name of Parents		
Child's Date of Birth	Home Phone Number	Address (Number & Street)		
Allergies, if any		City	State	Zip Code
Special Health Conditions, if any				
1. Parent's Location When Child's in Care (Employer, School, etc.)		Hours of Employment	Phone Number ()	
Address (Number & Street)		City	State	Zip Code
2. Parent's Location When Child's in Care (Employer, School, etc.)		Hours of Employment	Phone Number ()	
Address (Number & Street)		City	State	Zip Code

Person Other Than Parent To Be Notified In Emergency Situation When Parent Is Not Available

Name	Phone Number ()		
Address (Number & Street)	City	State	Zip Code

Names of Persons Other Than Parent To Whom Child May Be Released

1.	3.
2.	4.

Emergency treatment & transportation:

I hereby give permission to _____
(Child Care Provider)

Licensed by the Division of Child Development to secure emergency medical, dental, and/or emergency surgical treatment and to provide emergency transportation for the above named minor child while in care.

Non-emergency medical treatment or elective surgery is not included in this authorization.

Signature of Parent or Guardian	Date Signed
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Name of Child's Physician or Health Clinic	Office Hours	Phone Number ()	
Address (Number & Street)	City	State	Zip Code
Hospital Preferred for Emergency Treatment	Health Insurance Policy Name & Number		
Name of Child's Dentist	Office Hours	Phone Number ()	
Address (Number & Street)	City	State	Zip Code

Activities Outside the Fenced Playground

I hereby give permission to _____ For my child to participate in a walking trip or to participate in developmentally appropriate supervised activities outside of the fenced playground.
(Child Care Provider)

Signature of Parent of Guardian	Date Signed
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