

Date Application Completed \_\_\_\_\_

Date of Enrollment \_\_\_\_\_

### CHILD'S APPLICATION FOR ENROLLMENT

To be completed, signed, and placed on file in the facility on the first day and updated as changes occur and at least annually  
Revised 10/2016

**CHILD INFORMATION:**

Date of Birth: \_\_\_\_\_

Full Name: \_\_\_\_\_  
Last First Middle Nickname

Child's Physical  
Address: \_\_\_\_\_

**FAMILY INFORMATION:**

Child lives with: \_\_\_\_\_

Father/Guardian's Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address (if different from child's) \_\_\_\_\_ Zip Code \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_

Mother/Guardian's Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address (if different from child's) \_\_\_\_\_ Zip Code \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_

**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. 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	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\_\_