Date Application Completed _____

Date of Enrollment _____

For Office Use Only	
FT	1 2 3 4 5
PT	1 2 3 4 5

CHILD'S APPLICATION FOR ENROLLMENT 2018-2019

CHILD INFORMATION: Male _____ Female _____ Date of Birth _____

Full Name: _____

First Middle Last Nickname

Child's Physical Address: _____

FAMILY INFORMATION: Child lives with: _____

Father/Guardian's Name _____

Address (if different from child's) _____

Work Ph _____ Cell Ph _____ Home Ph _____

Email Address

Mother/Guardian's Name _____

Address (if different from child's) _____

Work Ph _____ Cell Ph _____ Home Ph _____

Email Address

CONTACTS:

Child will be released only to the parents/guardians listed above. The child can also 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
Name	Relationship	Address	Phone
Name	Relationship	Address	Phone
Name	Relationship	Address	Phone

Signature of Parent/Guardian Date

Child's Name _____ Date of Birth _____

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 all allergies (including food 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 these health care needs or concerns.

List any particular fears or unique behavior characteristics the child has.

List any types of medications taken for health care needs.

Share any other information that has a direct bearing on assuming safe medical treatment for your child.

Emergency Medical Care Information

Physician Address Telephone

Hospital Preference

Parent's Primary Insurance Company Insurance Group Number

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

2) I understand that my child may participate in physical activities such as those held during classroom time, playground time, music and movement, fall festivals (including but not limited to inflatables and bounce houses), etc. As with any physical activity, there is risk of injury. I fully accept this risk and hold harmless from any legal liability, The Growing Place/MVBC and any person in The Growing Place staff.

3) In the event of an emergency that requires medical treatment for the above named child, I understand every effort will be made to contact me or my emergency contact. However, if I/we cannot be reached, I give my permission to The Growing Place, MVBC Directors, and/or designated staff to transport my child. In addition, I grant permission for the same to secure licensed EMT to transport my child and secure the services of a licensed physician to provide the care necessary for my child's well being. I assume responsibilty for all costs connected to any accident or treatment of my child.

4) I understand that if the medical needs of my child changes during the school year, it is my responsibilty to update this document and properly inform The Growing Place staff of said changes.

Parent/Guardian Signature: Date

Office Use Only: I, as the operator, do agree to provide transporation 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 adminster any drug or any medication without specific instructions from the physician or the child's parent, guardian, or full time custodian.

Signature of Administrator: Date