



APPLICATION FOR ADMISSION

Child's Full Name \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_

Nickname \_\_\_\_\_

Address (Include city and zip code)

\_\_\_\_\_

Primary Language \_\_\_\_\_ Do Relevant Custody Papers Apply ( )Yes ( )No

Date of Admission: \_\_\_\_/\_\_\_\_/\_\_\_\_ Days in Care: M T W TH F Hours in Care: \_\_\_\_ a.m. until \_\_\_\_ p.m.

District employee (Check all that applies) \_\_\_ Mother \_\_\_ Father \_\_\_ Grandparent \_\_\_ Civil Partner

Employment Site \_\_\_ Barclay \_\_\_ Brookside \_\_\_ Mill Lake \_\_\_ Oak Tree \_\_\_ Applegarth

\_\_\_ Woodland \_\_\_ MTMS \_\_\_ MTHS \_\_\_ Central \_\_\_ PPS \_\_\_ Transportation

Mother's Name \_\_\_\_\_

Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ - \_\_\_\_\_

Business Name \_\_\_\_\_

Business Phone \_\_\_\_\_ - \_\_\_\_\_

Business Address \_\_\_\_\_

Alt Number \_\_\_\_\_ - \_\_\_\_\_

Employee # (if applicable) \_\_\_\_\_

Email \_\_\_\_\_

Father's Name \_\_\_\_\_

Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ - \_\_\_\_\_

Business Name \_\_\_\_\_

Business Phone \_\_\_\_\_ - \_\_\_\_\_

Business Address \_\_\_\_\_

Alt Number \_\_\_\_\_ - \_\_\_\_\_

Employee # (if applicable) \_\_\_\_\_

Email \_\_\_\_\_

LOCAL EMERGENCY CONTACT PERSON(S) TO WHOM THE CHILD MAY BE RELEASED

Name	Relationship	Full Address	Telephone Number	Driver's License #
1.				
2.				
3.				
4.				

Name of child's physician / medical care provider

Telephone Number

Hospital Affiliation

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Child's Health Insurance Coverage

Policy Number

\_\_\_\_\_

\_\_\_\_\_

Special Disabilities (if any)

\_\_\_\_\_

Allergies (including medication reaction)

\_\_\_\_\_

Medical or dietary information necessary in emergency situation

\_\_\_\_\_

Additional Information regarding special needs

\_\_\_\_\_

Medication, Special Conditions

\_\_\_\_\_

PARENT'S / LEGAL GUARDIANS SIGNATURE IS REQUIRED BELOW TO INDICATE CONSENT

Administration of Minor First-Aid Procedures

Obtaining Emergency Medical Care

X \_\_\_\_\_

x \_\_\_\_\_

X \_\_\_\_\_

\_\_\_\_\_

Signature of Parent / Legal Guardian

Date