Date Application Completed or Updated _____ Date of Enrollment _____

Trinity Baptist Weekday Preschool
Child's Application for Enrollment
(Required by licensing)

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 _____

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

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 Phone Number
_____
Name Relationship Address Phone Number

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
_____
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? Y__ N__
List any allergies and 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 medication taken for health care needs _____
Share any other information that has a direct bearing on assuring safe medical treatments 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, 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.

Signature of Administration _____ Date _____