Child's Application For Enrollment

Date Completed:_____

Enrollment Date:_____

Enrollment Fee Paid:_____

How did you hear about Kids 'R' Kids?_____

Child's Information:

Last_____First_____ Middle_____ Nickname_____

Age _____ Gender_____ Date of Birth _____ Child's Physical Address _____

Family Information:

Child Lives With_____

Mother/Guardian's Name_____Cell Phone_____

Address (if different from child's):_____

Home Phone_____ Work Phone_____ Additional Phone_____

Mother's SSN_____Mother's Drivers License Number_____ Mother's Email Address_____

Father/Guardian's Name_____Cell Phone_____

Address (if different from child's):_____

Home Phone_____ Work Phone_____ Additional Phone _____

Father's SSN_____Father's Drivers License Number_____ Father's Email Address_____

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
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

Kids 'R' Kids agrees to provide care for my child on M-T-W-T-F From_____to_____ Assigned Classroom_____

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 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 and 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. _____

_____

List any food restrictions or special diets. _____

Emergency Medical Care Information:

Name of health care professional _____Office Phone _____

Hospital the center uses **Cone Health Med Center** Address **2630 Willard Dairy Rd., High Point, NC 27265** Phone Number **(336) 884-3777**

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

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 child's parent, guardian, or full-time custodian. Signature _____ Date _____