DEVELOPING EAGLES - APPLICATION FOR ENROLLMENT

Department of Health & Heman Services
DHHS
NEBRASKA

Division of Public Health - Licensure Unit - Children's Services Licensing Program

Children's Record

PARENTS: PLEASE FILL IN ALL BLANKS

Child(ren)'s Name: _____ Birthdate(s): _____ **Grade in 20/21:** _____

Enrollment Date: _____ Email Address _____

Parent or Guardian's Home Address and Employment Address

Adult #1 ☐ Legal Custody ☐ OK to Pickup

Name: _____ Employer: _____

Relationship _____ Address: _____

Address: _____ City: _____ Phone: _____

City: _____ Phone: _____

Adult #2 ☐ Legal Custody ☐ OK to Pickup

Name: _____ Employer: _____

Relationship _____ Address: _____

Address: _____ City: _____ Phone: _____

City: _____ Phone: _____

Person(s) to Whom the Child(ren) may be Released by the Caregiver: (If no one, please write "none")

Name _____ Name _____

Address: _____ Address: _____

City: _____ Phone: _____ City: _____ Phone: _____

Name: _____ Name _____

Address: _____ Address: _____

City: _____ Phone: _____ City: _____ Phone: _____

Person(s) Who Will Take Responsibility for the Child(ren) in an Emergency When the Parent (or Guardian) Cannot be Reached: (ONE NAME MUST BE GIVEN)

Name: _____ Name _____

Address: _____ Address: _____

City: _____ Phone: _____ City: _____ Phone: _____

Name: _____ Name _____

Address: _____ Address: _____

City: _____ Phone: _____ City: _____ Phone: _____

Consent to Contact Physician in Emergency:

In the event I cannot be reached to make arrangements, I hereby give my consent to _____
Caregiver

to contact Doctor _____ Phone: _____
Name of Physician

_____ and, if necessary, take my child(ren) to the
Address City

following doctor(s), clinics, or hospital _____

_____ _____
Signature of Parent/Guardian Date

MEDICATION COMPETENCY STATEMENT

i, _____ have determined
Parent/Guardian Name

_____

that _____ is/are competent to give or apply medication to my child(ren)
Provider/Director/Staff Name(s)

_____ _____
Signature of Parent/Guardian Date

CHILD'S MEDICAL INFORMATION

Current health status or any health problems caregiver should know: _____

Medication, if any: _____

List any alergies and/or intolerance to food, insect bites, or stings, or other factors that result in a medical reaction. Please give clear instructions in the event of an exposure of the factor: _____

Special Concerns: (glasses, Hearing Aid, Crutches) _____

Any activities child(ren) should NOT engage in: _____

Company providing health and/or accident insurance coverage: (Optional) _____

I certify that the above information is correct to the best of my knowledge.

_____ _____
Signature of Parent/Guardian Date

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