DEVELOPING EAGLES – APPLICATION FOR ENROLLMENT

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):________________________

Enrollment Date:________________ Email Address ________________________

Parent or Guardian's Home Address and Employment Address:

FATHER (or Guardian):

Name: ________________________ Employer:________________________

Address:________________________ Address:________________________

City: ____________ Phone: ____________ City: ____________ Phone:____________

MOTHER (or Guardian):

Name: ________________________ Employer:________________________

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 ______________________________ ______________________________
Name of Physician Phone

______________________________ 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 allergies 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