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): __________ **Grade in 24/25:** __________

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

Developing Eagles is supported in part by 21st Century Community Learning Center federal funds under Title IV, Part B of the Elementary and Secondary Education Act as amended.