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 19/20:** ____________

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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