

# 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 22/23: \_\_\_\_\_

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 \_\_\_\_\_

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