Date Application Completed_____ Date of Enrollment_____

CHILD'S APPLICATION FOR ENROLLMENT

To be completed, signed, and placed on file in the facility on the first day and updated as changes occur and at least annually

CHILD INFORMATION: Date of Birth: _____

Full Name:

_____

Last First Middle Nickname

Child's Physical Address:

_____

FAMILY INFORMATION: Child lives with: _____

Father/Guardian's Name _____ Home Phone_____

Address (if different from child's) _____Zip Code _____

Work Phone _____Cell Phone_____

Email _____

Mother/Guardian's Name _____Home Phone_____

Address (if different from child's) _____Zip Code _____

Work Phone _____Cell Phone_____

Email _____

CONTACTS:

Child will be released only to the parents/guardians listed above. The child can also be released to the following individuals, as authorized by the person who signs this application. In the event of an emergency, if the parents/guardians cannot be reached, the facility has permission to contact the following individuals.

_____

Name Relationship Address Phone Number

_____

Name Relationship Address Phone Number

_____

Name Relationship Address Phone Number

HEALTH CARE NEEDS:

For any child with health care needs such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child's parent or health care professional. Is there a medical action plan attached? Yes____ No____

List any allergies and the symptoms and type of response required for allergic reactions._____

_____

_____ _____

List any health care needs or concerns, symptoms of and type of response for these health care needs or concerns._____

_____

List any particular fears or unique behavior characteristics the child has_____

_____

List any types of medication taken for health care needs_____

Share any other information that has a direct bearing on assuring safe medical treatment for your child_____

_____

EMERGENCY MEDICAL CARE INFORMATION:

Name of health care professional _____Office Phone _____

Hospital preference _____Phone _____

I, as the parent/guardian, authorize the center to obtain medical attention for my child in an emergency.

Signature of Parent/Guardian _____Date_____

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or any medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian.

Signature of Administrator_____Date_____

NewBridge
CHILDREN'S ACADEMY

Child's Background Information

Does your child separate easily from you? _____

Has your child ever been in child care? _____

What kinds of activities does your child enjoy?

_____

_____

_____

What is his/her daily routine?

_____

_____

_____

What kinds of self-care activities is your child able to do by him/herself?
(dressing, washing, etc.)

_____

_____

Where will your child go to school after NewBridge Children's Academy?

_____

How did you hear about NewBridge Children's Academy?

_____

If your child has special needs, please explain.

_____

_____

What immediate goals do you have for your child's development-academically, socially, and emotionally?
Why would you like to enroll your child at NewBridge Children's Academy?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

NewBridge
CHILDREN'S ACADEMY

Child's Immunization History

Name: _____ **Birth Date:** _____ _____

Enter the date an immunization was received in the space below or attach a copy of the immunization record. G.S. 130A-155(b) requires all child care facilities to have this information on file.

Enter date of each dose – Month/Day/Year

VACCINE	#1	#2	#3	#4	#5
*DTP / DT (circle which)					
*Polio					
**Hib					
***Hepatitis B					
*MMR (combined doses)					
****Chicken Pox					
OTHER					
OTHER					

*Required by State law.
**Required by State law for children born on or after 10/1/88.
***Required by State law for children born on or after 7/1/94.
****Required by State law for children born on or after 4/1/01.

Records Updated By:	Date Updated:

NewBridge
CHILDREN'S ACADEMY

Child's Medical Report

Name of Child_____Birth Date_____
Name of Parent or Guardian_____
Address of Parent of Guardian _____

A. Medical History (May be completed by parent)
1. Is child allergic to anything? No___ Yes___ If yes, what? _____

2. Is child currently under a doctor's care? No___ Yes___ If yes, for what reason? _____

3. Is the child on any continuous medication? No___ Yes___ If yes, what? _____

4. Any previous hospitalizations or operations? No___ Yes___ If yes, when and for what?

5. Any history of significant previous diseases or recurrent illness? No___ Yes___ ;
Diabetes? No___Yes___; Convulsions? No___ Yes___; Heart Trouble? No___ Yes___.
If others, what/when? _____
6. Does the child have any physical disabilities: No___ Yes___ If yes, please describe: _____

Any mental disabilities? No___ Yes___ If yes, please describe: _____
Signature of Parent or Guardian_____Date_____

B. Physical Examination: This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the N. C. Board of Medical Examiners (or a comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting DEHNR standards for EPSDT program.

Height _____% Weight _____%

Head_____ Eyes_____ Ears_____ Nose_____ Teeth_____ _____
Throat_____ Neck_____ Heart_____Chest_____Abd/GU_____
___
Ext_____Neurological System_____Skin_____
___

Results of Tuberculin Test, if given: Type_____Date_____Normal___Abnormal_____
Should activities be limited? No___ Yes___ If yes, explain:_____ __
Any other recommendations: _____ __
_____ Date of
_____ Examination_____

_____ _____ _____ __
Signature of Authorized Examiner/Title **Date** **Phone #**