NewBridge
CHILDREN'S ACADEMY

Application Date _____ Date of Enrollment_____

Name of Child _____ Birth date _____
(Last) (First) (MI) (Nickname)
Address _____Zip Code _____

INFORMATION ABOUT YOUR FAMILY:

Father/Guardian's Name_____
Cell Phone _____Work Phone _____Home Phone _____
Address _____Zip Code_____
Employer _____
Email Address _____

Mother/Guardian's Name _____
Cell Phone _____Work Phone _____Home Phone _____
Address _____Zip Code_____
Employer _____
Email Address _____

Insurance Carrier _____Policy # _____

INFORMATION ABOUT YOUR CHILD:

Does your child have any known allergies: No____ Yes____
Explain: _____
Does your child have any chronic illnesses/conditions: No____ Yes____
Explain:_____
Please give any information concerning your child which will be helpful in his experience in group setting (such as play, eating and sleeping habits, special fears, special likes or dislikes)._____
_____

EMERGENCY CARE INFORMATION:

Name of child's doctor _____Office Phone_____
Address_____
Hospital preference_____Phone _____
If neither father nor mother (or guardian) can be contacted, call (please list relationship):
Name_____Phone _____Phone _____
Name_____Phone _____Phone _____
If you cannot call for your child, please give the names of persons to whom the child can be released:
_____
_____

I agree that the operator may authorize the physician of his/her choice to provide emergency care in the event that neither I, nor the family physician, can be contacted immediately.

_____
(Signature of Parent) (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. Provisions will be made for adequate and appropriate rest and outdoor play.

_____
(Signature of Operator) (Date)

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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?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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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:

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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 #**