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:_____ Zip Code _____

FAMILY INFORMATION: Child lives with: _____

Father/Guardian's Name _____ Home Phone_____

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

Work Phone_____ Cell Phone_____ Email Address _____

Mother/Guardian's Name _____ Home Phone _____

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

Work Phone _____ Cell Phone_____ Email Address _____

CONTACTS:

Typically, the child will be released 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: **Is there a medical action plan attached? Yes__ No__**

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.

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_____

List any learning differences, academic or behavior challenges for your child. _____

EMERGENCY MEDICAL CARE INFORMATION:

Name of health care professional _____ Office Phone _____

Hospital preference _____ Phone _____

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

Signature of Parent/Guardian_____Date_____

I, as the operator, do agree to seek 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_____

This form must be reviewed, updated and signed annually. I, as the parent/guardian, reviewed and updated the information contained on this form on:

Date_____ Signature_____ Date_____ Signature_____ Date_____ Signature_____

Date_____ Signature_____ Date_____ Signature_____ Date_____ Signature_____