Albemarle Preschool

"Inspiring excellence and character in a nurturing environment."

Application for Enrollment

Please do not leave any line blank. Put "NA" if there is no response.

Child Information:

Full name: _____

Last First Middle Nickname

Child's Physical Address: _____

Family Information: Child Lives with: _____

Mother/Guardian's Name: _____ Cell Phone: _____

Address (If different from Child's): _____ Zip Code: _____

Place of Employment:_____ Work Number: _____

Email Address: _____

Father/Guardian's Name: _____ Cell Phone: _____

Address (If different from Child's): _____ Zip Code: _____

Place of Employment:_____ Work Number: _____

Email Address: _____

Contacts: Child will only be released to the parents/guardians 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

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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 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 that occur, and type of response needed for these health care needs or concerns:

_____
_____
_____

List any particular fears or unique behavior characteristics the child has:

_____
_____
_____

List any types of medications 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 an emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian.

Signature of Administrator: _____ Date: _____