Child Admission Agreement

Name of Child	Nickname	Birth Date month/day/year	Sex (check one)	Enrollment Date (check the box if no longer enrolled)
		___/____ /____	F____ M____	___/____ /_____ ☐
		___/____ /____	F____ M____	___/____ /_____ ☐
		___/____ /____	F____ M____	___/____ /_____ ☐

Home Street Address _____ Phone # _____

City _____ State _____ Zip _____

Parent's/Guardian's Name _____ Phone # _____

Email _____ Work Phone # _____

Parent's/Guardian's Name _____ Phone # _____

Email _____ Work Phone # _____

Emergency Contacts (Other than Parents) and Persons Authorized to Pick -Up the Child

(Unless there is a court order prohibiting it, parents whose names are not listed can pick up their children.)

Name	Relationship to Child	Address	Phone #
☐ Check if there are no emergency contacts available, other than parents. ☐ Check if there are no persons authorized to pick up the child, other than parents.			
Out of Area/State Contact Name (If available)	**Relationship to Child**	**Address**	**Phone #**
☐ Check if there are no out of area/state contacts available.			

In case of an emergency or a serious illness and the parents cannot be reached immediately, I hereby authorize the provider to obtain emergency medical care and/or provide emergency medical transportation for my child.

_____ _____/_____/_____

Name of Parent/Guardian Date

I hereby give the provider permission to transport my child in the provider's vehicle for the following (optional):

☐ To and From School ☐ On Field Trips (with written permission in advance) ☐ Other: _____

_____ _____/_____/_____

Name of Parent/Guardian Date

This form must be reviewed annually by the parent/guardian, and any changes noted.

Parent/Guardian Name:

Reviewed and/or update: _____/_____/_____ _____

Reviewed and/or update: _____/_____/_____ _____

Reviewed and/or update: _____/_____/_____ _____

This form is provided for technical assistance purposes only. Providers may use this form if they choose, but are **not** required to use this form.

Child Health Assessment

There must be a separate health assessment form for each sibling.

Name of Child _____ Birth Date _____/_____/_____

Check All That Apply:
Does your child have any known allergies or sensitivities to:

	No	Yes	If yes, please list:
Medications	☐	☐	_____
Foods	☐	☐	_____
Other	☐	☐	_____

Illnesses or Medical Conditions:
Does your child have any of the following conditions?

	No	Yes		No	Yes
Asthma	☐	☐	Visual Impairment	☐	☐
Diabetes	☐	☐	Developmental Delays	☐	☐
Seizures	☐	☐	Physical Impairment	☐	☐
Heart Problems	☐	☐	Behavioral or Emotional Problems	☐	☐
Hearing Impairment	☐	☐	Other: _____		

List any additional health information or special instructions you feel we need to be aware of:

_____

_____

_____

List any regular medications your child takes: _____

Name of Child's Medical Provider: _____

_____ _____/_____/_____
Parent/Guardian Name Date

This form must be completed for each **individual** child enrolled, and must be reviewed annually by the parent/guardian, and any changes noted.

Parent/Guardian Name:

Reviewed and/or update: _____/_____/_____ _____

Reviewed and/or update: _____/_____/_____ _____

Reviewed and/or update: _____/_____/_____ _____

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