Date of Application ___________

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 Preferred Name

Address: ____

Family Information: Child lives with: ______________________

Father/Guardian's Name: ______________________________________ Home Phone: _____________

Address (if different from child's): ____

Place of Employment: ____________________________________ Work Phone: ______________

Email Address: ____ Cell Phone: ________________

Mother/Guardian' Name: ______________________________________ Home Phone: ______________

Address (if different from child's): ____

Place of Employment: ____________________________________ Work Phone: ______________

Email Address: ____ Cell Phone: ________________

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 required 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: _____________

____

____

Date of Application ___________ Date of Enrollment ________

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. I understand that in an emergency situation, my child will be transported in a staff member's personal vehicle to an appropriate and designated location.

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 any medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian.

Signature of Administrator: __________________________________ Date: ___________________

Optional Information:

Is your child being raised by 1 or more Jewish parents? ________ yes ________ no

If so, would you like information about our Religious School program for 3 and 4-year old children? (Kehillah Synagogue Membership is not required.) _______ yes ________ no

Are you interested in information on Kehillah Synagogue Membership? ________ yes _________ no

May I share your name and email address with the Parent Group Leadership Committee? They will contact you about parent involvement opportunities with KJP. _______ yes _________ no