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: _____

FAMILY INFORMATION: Child lives with: _____

Parent I/Guardian's Name _____ Home Phone _____

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

Work Phone _____ Cell Phone _____

Parent II/Guardian's Name _____ Home Phone _____

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

Work Phone _____ 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
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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 action 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 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.

Signature of Parent/Guardian _____ 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.

Signature of Administrator _____ Date _____

Child's Gender ____M ____F

Email Address _____

Are you interested in ¾ day (7:30-3:30) or ½ day (7:30-12:30 for Preschoolers or 8:00-12:00 for Toddlers) care? _____ 5 days or part week? _____

Other children in the family:

Name _____ Age _____
Name _____ Age _____
Name _____ Age _____

Office use
app conf. ___
tour date ____

Has your child had experience with group child care before?
Describe:

_____
_____
_____

Parent participation is an integral part of our program. Do you understand that each family is required to participate for a minimum of 2 hours per month?

_____

What are you, as parents, looking for in a preschool. What do you hope to find at the Weaver Dairy Community Preschool?

_____
_____
_____
_____

Parent or guardian signature

Please return your completed application to:

Weaver Dairy Community Preschool
124 Weaver Dairy Rd.
Chapel Hill, NC 27514
wdcp@nc.rr.com
weaverdairypreschool.com

Please include the $25.00 application fee.