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:____

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
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 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:

		Office use
Name __________________________________	Age __________	app conf. ___
Name __________________________________	Age __________	tour date ____
Name __________________________________	Age __________	

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.