CHILD CARE APPLICATION/EMERGENCY RECORD FORM-St. Louis CDC

Today's Date:_____ **(Office Use Only) Enroll. Date: Term Date:**

Child's Name:_____ Gender: __ M __F D.O.B:_____/_____/_____

Child's Address:_____

Mailing Address (if different):

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The person you list as the "1st. Parent" will be the one that is contacted first for any emergency. What is the best method to contact this person: hm #_____ cell#_____ wk#_____ other_____

For other, describe:

1st. Parent/Guardian Name:_____

Home #:_____ _____ Cell #:_____

Address:_____

City:_____ State:__ME_____ Zip:_____

Mailing address (if different):_____

E-mail Address:_____ Do You text? _____ Yes _____ No

Place of Employment:_____ Work Phone:_____

Employment Address:_____

Employment Mailing Address (if different):_____

E-mail Address:_____

2nd. Parent/Guardian Name:_____

Home #:_____ Cell#:_____

Address (if different):_____

City:_____ State:____ME_____ Zip:_____

E-mail Address:_____ Do You text? Yes _____ No _____

Mailing address (if different):_____

Place of Employment:_____ Work Phone:_____

Employment Address:_____

Employment Mailing Address (if different):_____

Emergency numbers to be contacted in case parent(s) cannot be reached in an emergency:

Name:_____ Relationship:_____ Phone:_____

Street Address:_____

Name:_____ Relationship:_____ Phone:_____

Street Address:_____

Name of people not listed above who are permitted to remove the child(ren) from the Center:

_____ _____ _____

Other Side----

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MEDICAL INFORMATION

Name of Child's Physician:_____ Phone #:_____

Address:_____ City/State/Zip:_____

Last Tetnus Shot Date:_____

Name of Medical Insurance Plan:_____ **Insurance ID #:**_____

Does your child have a dentist? _____ Yes _____ No

Name of Child's Dentist _____ Phone #:_____

Address:_____ City/State/Zip:_____

Does your child have a history of; allergies, ear infections, frequent sore throats, asthma, seizures, serious illnesses or any other special medical needs of which we should be aware? _____Yes _____No

If yes, please list?

_____

_____

_____

_____

Please attach instructions for any special medical needs.

How is your child's current health: _____ good _____ I have concerns If you have concerns, please describe:

"I hereby give my consent, in the event of a medical emergency when I cannot be contacted, for child care staff to obtain whatever treatment may be deemed necessary

for_____ _____"
Child's Name D.O.B.

This authorization includes my consent for the above named child to receive treatment by a physician in any hospital emergency department.

I hereby give my authorization for emergency medical treatment as outlined above.

_____ _____
Parent/Guardian Signature Date

Additional Application Information

Child Information

Has your child ever been in another child care center or nursery school? _____ yes _____ no

If yes: Where_____ For how long_____

Has your child ever been screened/evaluated by CDS or any other Early Intervention System?

_____ yes _____ no If yes, please explain:

What would you like your child to experience at the center?

Do you have any concerns about your child being in a group setting? (These may include a short attention span, difficulty sitting, temper tantrums, difficulty waiting for a turn, hitting, screaming, etc.) If yes, please explain:

Is there any other information not yet mentioned that will help us understand your child better?

Family Information

Marital Status: ____ Single ____ Married

Primary Language: _____ English _____ Other (describe:_____)

Preferred Language for Communication: _____

US Census Category: ____ White/Caucasian ____ Black/African American
____ Native American/Alaskan ____ Hispanic/Latino ____Asian ____ Other

Religion:_____

How did you find out about the center:_____

Fee/Enrollment Information

Child care is needed by this date: _____

Type of child care needed: ____ Full Time ____ Part Time ____ How many hours/wk

Which days are needed: ____ Mon. ____ Tues. ____ Wed. ____ Thurs. ____ Fri.

I will pay my fee: ____ Privately ____ With a DHHS Voucher ____ With an Aspire Voucher

Your signature verifies that all information on the 3 pages of the Application/Emergency

Record Form is correct: _____ Date:_____

Signature