Child Enrollment Agreement & Health Assessment

Child's Full Name: ____

Birthdate: _____/_____/_____ Sex: (M / F) Class: ____________________

Enrollment Date: _____/_____/_____**Email:** __________________________

Home Address: ____Phone#________________

City____State________________________Zip__________

Mother's/Guardian's Name:		Cell Phone#	
Employer		Work Phone#	
Father's/Guardian's Name:		Cell Phone#	
Employer		Work Phone#	

Siblings

Name:	Age:	Name:	Age:
Name:	Age:	Name:	Age:

Emergency Contacts & Persons Authorized to Pick-up (other than parents)

Check if there are no persons authorized to pick up the child other than parents.

Name	Relationship to child	Address	Phone number

Out of Area:

Name	Relationship to child	Address	Phone number

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

____ _________/________/_________

Signature of Parent or Guardian Date

I hereby give the provider permission for my child to go on any field trip that will be taken away from the center, with the understanding that I will be informed of the field trip in advance. Exceptions (Please List): ____

____ _________/________/_________

Signature of Parent or Guardian Date

I hereby give permission for photographs, video, audio, and artist renditions to be taken of my child while enrolled in St. John's CCDC programs. I allow St. John's CCDC to release said images for the promotion and publicity of the center, including website (names are always omitted).

Yes No Exceptions (Please list): ____

____ _________/________/_________

Signature of Parent or Guardian Date

Child Health Assessment

(Please Write Clearly)

Name of Child____Birthdate_______/_______/________

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?

	No	Yes		No	Yes
Asthma	◯	◯	Visual Impairment	◯	◯
Diabetes	◯	◯	Developmental Delays	◯	◯
Seizures	◯	◯	Physical Impairment	◯	◯
Heart Problems	◯	◯	Behavioral /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: ______________________________________**Phone#**____________________

____ ________/_______/________

Signature of Parent or Guardian Date

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

Reviewed and/or update: _____/_____/_____ Parent/Guardian Signature: ______________________________

Reviewed and/or update: _____/_____/_____ Parent/Guardian Signature: ______________________________

Reviewed and/or update: _____/_____/_____ Parent/Guardian Signature: ______________________________

Reviewed and/or update: _____/_____/_____ Parent/Guardian Signature: ______________________________