Application Date_______________
Date of Enrollment_______________
Registration Fee_______________

Total Child Care Center, Inc.
CHILD'S APPLICATION FOR DAY CARE

To be completed and placed on file prior to enrollment

Name of Child____Birth Date____________
(last) (first) (middle) (nickname) S.S. #________________
Address____ Zip Code_____________

INFORMATION ABOUT THE FAMILY:

Father/Guardian's Name____Home Phone__________
Address____Zip Code__________
Where Employed____Business Phone__________
Other Phone__________
Mother/Guardian's Name____ _ Home Phone__________
Address____Zip Code__________
Where Employed____Business Phone__________
Other Phone__________
Names and ages of siblings____
Insurance Carrier____Policy #________________
e-mail ____

INFORMATION ABOUT YOUR CHILD:

Does your child have any known allergies: no______ yes______ Has your child eaten peanut butter?______
Explain:
Please give any information concerning your child, which will be helpful in his experience in a group setting:
(Such as playing, eating, and sleeping habits, special fears, likes and dislikes)

EMERGENCY CARE INFORMATION:

Name of child's doctor ____Office phone____________
Address____
Name of child's dentist____ Office phone____________
Address____
Hospital preference____Phone__________________
If neither father nor mother *(or guardian) can be contacted,* call *(please list relationship)*:
Name ____________________________________Home phone ______________Work phone_____________
Name ____________________________________Home phone ______________Work phone_____________
If you cannot call for your child, please give the names of persons to whom the child can be released:
____

I agree that the operator may authorize the physician of his/her choice to provide emergency care in the event that neither the family physician nor I can be contacted immediately.

____
(Signature of parent) (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, a responsible adult will supervise other children in the facility. 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. Provisions will be made for adequate rest and outdoor play.

____
(Signature of Operator) (Date)

TOTAL CHILD CARE CENTER, INC.
CHILDREN'S MEDICAL REPORT

Name of child____
Name of Parent/Guardian____
Address of Parent/Guardian____

A: Medical History *(May be completed by parent)*

1.Is child allergic to anything? No_____ yes_____ what? ______________________________

2.Is child currently under a doctor's care? No_____ Yes____ For What Reason____________________

3.Is child on any continuous medication No_____ Yes____ What? ______________________________

4.Any previous hospitalization or operations? No____ Yes_____ When /for what? ____________________

5.Any history of significant previous diseases or recurrent illness? No___ Yes____

Diabetes: No_____ Yes____ Convulsions: No____ Yes______ Heart trouble No_____ Yes________

If others, what /when____

6.Does the child have any physical disabilities: No ____yes_____ If yes, please describe: ______________
____
Any mental disabilities? No____ Yes ____If yes, please describe: ____________________________________
____

Signature of Parent/Guardian____

B: Physical Examination: This examination must be completed and signed by a licensed physician, his authorized agent currently approved by N.C, Board Of Medical Examiners *(or a comparable board from bordering states),* a certified nurse practitioner, or a public health nurse meting DEHNR standards for EPSDT program.

Height__________% Weight___________%
Head____________ Eyes__________ Ears__________ Nose__________ Teeth_________
Throat__________ Neck__________ Heart_________ Chest__________ Bad/GU________
Ext______________ Neurological System____________________________________ Skin___________

Results of Tuberculin Test, if given: Type_____________ date__________ Normal______ Abnormal_________

Should activities be limited? No___ Yes_____ If yes, explains:
____

Any recommendations: ____

Signature of authorized examiner/title____

Date of Examination ___________________________Phone #_________________________

Office Address
May use address stamp