Apple Blossom Academy Enrollment Agreement

Child's Information

First name Last name

Birth date Age Gender	Parent/guardian/sponsor primary language	Child's primary language

Child's home address	City	State	Zip

Family Information

With Whom does the child live :☐ Both Parents ☐ Mother ☐ Father ☐ Other If Parents are separated, single or divorced, who has legal custody ☐ Both Parents ☐ Father ☐ Mother If there is a court valid no-contact order in place? ☐ No ☐ Yes – A valid copy of No Contact must be provided to center staff.	List names and relation (include age of siblings) of all persons living in the home

Parent/guardian/sponsor	Relationship to child	Home phone	Cell phone

Home address if different from above	City	State	Zip

Email

Employer	Employer address	City	State	Zip	Work hours

Other parent/guardian/sponsor	Relationship to child	Cell phone

Home address if different from above	City	State	Zip

Email

Employer	Employer address	City	State	Zip	Work hours

Child Emergency Contact and Release Information (do not include parents/guardians/sponsors)

Please notify the center if an Emergency Release Contact will pick up your child on a given day. For the safety of your child, we request that all authorized pick up persons with whom staff is not familiar provide a photo ID at the time of pick up. The persons designated in this section will be contacted by us if you cannot be reached in the event of a medical or other emergency. Our staff will only release your child to you or to those persons listed. If you want a person who is not identified above to pick up your child, you must notify our staff in advance, in writing. Your child will not be released without prior authorization.

Person #1	Relationship to child	Cell phone

Home address	City	State	Zip

email

Person #2	Relationship to child	Cell phone

Home address	City	State	Zip

email

Person #3	Relationship to child	Cell phone

Home address	City	State	Zip

email

Completion of this entire agreement is required for enrollment. This form will enable us to better understand your child and meet his/her needs. Much of the information requested is necessary to comply with state child care licensing regulations. You certify that the information provided in this agreement is correct to the best of your knowledge.

Parent Signature_____ Date _____

Medical Information

Child's name	Birth date	Height	Weight	Hair color	Eye color

Distinguishing marks

Child's Medical & Developmental History

1. Does your child have any special medical conditions? □ No □ Yes Explain
2. Does your child have any chronic illnesses? □ No □ Yes Explain
3. Please list a brief history of your child's serious injuries and hospitalizations.
4. Does your child have diabetes? □ No □ Yes - *If yes, please attach health plan / care instructions from your physician.*
5. Does your child have asthma? □ No □ Yes - *If yes, please attach health plan / care instructions from your physician.*
6. Will medication be administered regularly? □ No □ Yes - *If yes, please complete supplemental medication permission form*
7. Does your child have any special dietary needs? □ No □ Yes - Explain
8. Is your child able to fully participate in all activities? □ Yes □ No: Explain
9. Does your child have any physical restrictions? □ No □ Yes: Explain
10. Does your child function at the level of other children in his/her age group? □ Yes □ No: Explain
11. Is your child able to walk □ Yes □ No
12. Can your child communicate his/her needs? □ Yes □ No
13. Does your child need assistance at meal time? □ No □ Yes Explain
14. Is your child toilet trained? □ No □ Yes
15. Does your child use any special equipment, such as breathing machine, wheelchair, hearing aid, braces, glasses etc.? □ No □ Yes: Explain
16. Does your child require one-to-one care/supervision on a regular basis for a significant period of time? □ No □ Yes: Explain
17. Does your child require any accommodations or modifications to fully and equally enjoy and participate in a group care setting? □ No □ Yes: Explain

Illness History *(please check all that apply)*

□ Vision problems
□ Hearing problems
□ Constipation
□ Diarrhea
□ Asthma/Respirtory
□ Nosebleeds
□ Skin rashes
□ Sore throats
□ Ear infections
□ Urinary tract infections
□ Seizures
□ Mouth sores
□ Fainting
□ Persistent cough
□ Other

Other Known Health Issues:

Disease History *(please check all that apply and add the date)*

□ Chicken Pox (Varicella)
□ Measles Rubeola
□ Rubella (German Measles)
□ Mumps
□ Scarlet Fever
□ Bronchiolitis
□ Pneumonia
□ Pertussis (Whooping cough)
□ Tetanus
□ Diphtheria
□ Botulism
□ Haemophilus Influenza
□ Meningococcal Infection
□ Rabies
□ Bacterial Meningitis

↓ KNOWN ALLERGIES

Medication Allergies	Reaction	**Food** Allergies	Reaction
Bee Stings Allergies	Reaction	**Respiratory** Allergies	Reaction
Other Allergies	Reaction	**Are any of these allergies life-threatening?**	□ **Yes** □ **No**

If Allergies Are Present Please Complete Supplemental Allergy and Anaphylaxis Emergency Plan || If Food Allergies/Intolerance Are Present Please Complete Supplemental Food Allergy/Intolerance Care Plan

Miscellaneous Screenings and Tests *(please check all that apply and add the date of last screening)*

□ Vision
□ Hearing
□ Speech
□ Developmental
□ Aptitude
□ Educational
□ Tuberculosis (PPD)
□ Sickle Cell Anemia
□ Other

Parent Signature_____ Date _____

Medical Information (continued)

Child's name	Birth date

Child's Medical Care Provider

Primary physician's name	Date of Last Medical Exam	Phone	
Physician's practice address	**City**	**State**	**Zip**
Preferred hospital/clinic for emergency care	**City**	**State**	
Dentist's name (optional)	**Date of Last Dental Exam**	**Phone**	
Dentist's practice address (optional)	**City**	**State**	**Zip**

Child's Insurance Provider

Child's health insurance provider name	Policy number	Secondary health insurance provider name	Policy number

Additional Medical Policies

	Initial
1. Prior to enrollment, I must provide the center with updated medical and immunization information for my child. This information is to be kept current and updated in accordance with state child care regulations.	
2. I agree to provide information to the child care center about my child's conditions, illnesses, allergies or other needs.	
3. If my child becomes ill with a reportable contagious disease, I understand that he/she will not be able to return until I bring in a physician's note stating that he/she is no longer contagious.	
4. If my child becomes ill during his/her time at the child care center, the staff will contact me to pick up my child. I will arrange for pick up as soon as possible and no later than ½ hour after being contacted. If I cannot be reached, the staff will contact those listed in the *Child Emergency Contact and Release* section.	

Emergency Medical Authorization & Consent

REQUIRED FOR ENROLLMENT AND ATTENDANCE

	Initial
I hereby give permission that my child (print full name) _____ may be given emergency treatment by a qualified staff member at America's Best/Another Best Childcare and Learning Center Inc.	
In case of a medical emergency, the staff will attempt to contact me followed by those listed in the *Child Emergency Contact and Release.*	
When I cannot be contacted, I authorize and consent to medical, dental, surgical, and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital, or aid car attendant, when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health. I waive my right of informed consent to such treatment.	
In case of a medical emergency, I agree that my child may receive first aid and/or CPR.	
In case of a medical emergency, I permit the transportation of my child to a local hospital or other urgent care facility, if necessary by paramedics or other emergency personnel.	
In case of a medical emergency, I will be responsible for the emergency medical expenses.	
In case of an accidental ingestion of a poisonous substance, I consent to my child being treated as directed by the Poison Control Center.	

Parent Signature _____ Date_____

Disaster Awareness / Out Of Area Contact: 100+ Miles Away

Our Crisis/Disaster Response Handbook is available for you to review. During a disaster, communication may become challenging. Often it is easier to contact an out-of-area phone number rather than a local or cell number.

Please provide an out of area contact (100+miles away).

Name	Relationship to child	Home phone	Cell phone

Parent Signature_____ Date _____

Other Agreements

Photo Release

I understand that photos will be taken of my child and displayed within the center. This assists with a sense of belonging, provides an aid for name recognition, and helps the child identify and/or initiate conversations regarding peers.

Initial _____

Media Release

Occasionally, photos will be taken of the children at the center for use within the center or on our website and/or Facebook. Please indicate that you authorize the use and reproduction of photographs of your child in conjunction with the program.

Initial _____

Parent Signature _____ Date _____