



Application Date _____

Date of Enrollment _____

Child's Application for Enrollment

Name of Child _____ Birth Date _____

(Last) (First) (MI) (Nickname)

Address _____ Zip Code _____

INFORMATION ABOUT THE FAMILY:

Father/Guardian's Name _____ Home Phone _____

Address _____ Zip Code _____

Where Employed _____ Business Phone _____

Mother/Guardian's Name _____ Home Phone _____

Address _____ Zip Code _____

Where Employed _____ Business Phone _____

Insurance Carrier _____ Policy # _____

INFORMATION ABOUT YOUR CHILD:

Does your child have any known allergies: No ___ Yes ___

Explain: _____

Please give any information concerning your child which will be helpful in his experience in group setting (such as play, eating and sleeping habits, special fears, special likes or 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 _____ Office Phone _____

Name _____ Home Phone _____ Office 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 I nor the family physician 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 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. Provisions will be made for adequate and appropriate rest and outdoor play.

(Signature of Operator)

(Date)



Child's Background Information

Does your child separate easily from you? _____

Has your child ever been in child care? _____

What kinds of activities does your child enjoy?

What is his/her daily routine?

What kinds of self-care activities is your child able to do by him/herself?
(dressing, washing, etc.)

Where will your child go to school after NewBridge Children's Academy?

How did you hear about NewBridge Children's Academy?

If your child has special needs, please explain.

What immediate goals do you have for your child's development-academically, socially, and emotionally?
Why would you like to enroll your child at NewBridge Children's Academy?



Child's Medical Report

Name of Child _____ Birth Date _____
 Name of Parent or Guardian _____
 Address of Parent of Guardian _____

A. Medical History (May be completed by parent)

1. Is child allergic to anything? No ___ Yes ___ If yes, what? _____

2. Is child currently under a doctor's care? No ___ Yes ___ If yes, for what reason? _____

3. Is the child on any continuous medication? No ___ Yes ___ If yes, what? _____

4. Any previous hospitalizations or operations? No ___ Yes ___ If yes, when and 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 or Guardian _____ Date _____

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

Height _____% Weight _____%

Head _____ Eyes _____ Ears _____ Nose _____ Teeth _____
 Throat _____ Neck _____ Heart _____ Chest _____ Abd/GU _____

Ext _____ Neurological System _____ Skin _____

Results of Tuberculin Test, if given: Type _____ Date _____ Normal ___ Abnormal _____

Should activities be limited? No ___ Yes ___ If yes, explain: _____

Any other recommendations: _____

_____ Date of Examination _____

Signature of Authorized Examiner/Title

Date

Phone #