

Knightdale Station Preschool
APPLICATION FOR CHILD CARE

Date of Enrollment _____

Name of Child: _____
(Last) (First) (Middle/Nickname)

Address: _____
(Street) (City) (State) (Zip Code)

Age of Child: _____ Birth Date: _____ Social Security #: _____

Information about the family:

Father/Guardian's Name: _____ Home Phone: _____ Cell Phone: _____

Address (if different from child's): _____
(Street) (City) (State) (Zip Code)

Where employed: _____ Business Phone: _____ NCDL# _____

Father's E-mail _____

Mother/Guardian's Name: _____ Home Phone: _____ Cell Phone: _____

Address (if different from child's): _____
(Street) (City) (State) (Zip Code)

Where employed: _____ Business Phone: _____ NCDL# _____

Mother's E-mail _____

If child is not living in home of parents, name of responsible adult _____

Relationship: _____ Address: _____

Home Phone: _____ Where Employed: _____ Business Phone: _____

If you can not call for your child, please give the names of persons to whom the child can be released to: _____

Health Care Needs: For any child with health care needs such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child's parent or health care professional. Is there a medical action plan attached? Yes ___ No ___

List any allergies and the symptoms and type of response required for allergic reactions. _____

List any health care needs or concerns, symptoms of and type of response for these health care needs or concerns _____

List any types of medication taken for health care needs _____

Share any additional information that has a direct bearing on assuring safe medical treatment for your child _____

List any particular fears or unique behavior characteristics _____

Emergency Care Information:

Child will be released only to the parents/guardians listed above. In the event of an emergency, if the parents/guardians cannot be reached, the facility has permission to contact the following individuals.

Name: _____ Address: _____ Phone: _____

Name: _____ Address: _____ Phone: _____

Name: _____ Address: _____ Phone: _____

Name of health care professional: _____ Office Phone: _____

Hospital preference: _____ Phone: _____

I, as the parent/guardian, authorize the center to obtain medical attention for my child in the event of an emergency.
I have received a copy of the Summary of the North Carolina Child Care Law and Rules.

(Date) (Signature of Parent/Guardian)

I, as the director, 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.

(Date) (Signature of Director)