A LEAP OF FAITH CDC ENROLLMENT APPLICATION

P.O.C#1710418600

CHILD INFORMATION			
Name:			
DOB:	Age:	Sex:	Nickname:
Address:			
City:	State:	ZIP:	

CHILD INFORMATION			
Name:			
DOB:	Age:	Sex:	Nickname:
Address:			
City:	State:	ZIP:	

PARENT INFORMATION		
Name:	Relationship:	
Address:		
City:	State:	ZIP:
Home:	Cell:	Work:
Email address:		Preferred contact:

SPOUSE/CO-PARENT INFORMATION		
Name:	Relationship:	
Address:		
City:	State:	ZIP:
Home:	Cell:	Work:
Email address:		Preferred contact:

CHILD'S LEGAL RESIDENCE INFORMATION		
Name of legal guardian :		
Address:		
City:	State:	ZIP:
Home:	Cell:	Work:

CHILDCARE SCHEDULE REQUIREMENT		
Monday	AM	PM
Tuesday	AM	PM
Wednesday	AM	PM
Thursday	AM	PM
Friday	AM	PM

EMERGENCY/PICK-UP AUTHORIZATION VALID IDENTIFICATION IS REQUIRED PRIOR TO CHILD BEING RELEASED		
Name	Number:	Relationship:
Name	Number:	Relationship:
Name	Number:	Relationship:
Signature:		Date:

ORIENTATION CHECKLIST

Child's Name

List your child's favorite…

Breakfast Food: _____

Lunch Food: _____

Snack Food: _____

Song(s): _____

Books: _____

Videos: _____

Toy: _____

Cartoon Character: _____

Game: _____

Indoor Activity: _____

Outdoor Activity: _____

I my child has trouble falling asleep I usually: _____

_____

My child is affaid of: _____

_____

Other people who have regular contact and are involved in the care of my child

Name And Relationship

Name And Relationship

Name And Relationship

Name And Relationship

Name And Relationship

Name And Relationship

Name And Relationship

Name And Relationship

Please provide and other information you woud like to share about your child to him/her feel more comfortable to provide a smooth transition through the orientation process:

EMERGENCY CONTACT AND MEDICAL INFORMATION FOR A CHILD

Child's Name

Date of Birth

M F
Sex

Parent's/Guardian's Name

Home Phone

Work Phone

Address

City, ST ZIP Code

Parent's/Guardian's Name

Home Phone

Work Phone

Address

City, ST ZIP Code

ALTERNATIVE EMERGENCY CONTACTS

Primary Emergency Contact And Relationship

Home Phone

Work Phone

Address

City, ST ZIP Code

Secondary Emergency Contact And Relationship

Home Phone

Work Phone

Address

City, ST ZIP Code

MEDICAL INFORMATION

Hospital/Clinic Preference

Physician's Name

Phone Number

Insurance Company

Policy Number

Allergies/Special Health Considerations

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

Parent's/Guardian's Signature

Date

I give permission for my child to go on field trips. I release A Leap of Faith CDC and individuals from liability in case of accident during activities related to A Leap of Faith CDC, as long as normal safety procedures have been taken.

Parent's/Guardian's Signature

Date

Witness Signature

Date

PARENTS RIGHT TO KNOW

Child's Name

UNDER THE DELAWARE CODE YOU ARE ENTILED TO INSPECT THE ACTIVE RECORD AND ANY COMPLIANT FILES OF NY LICENSED CHILD CARE FACILITY. TO REVIEW A CHILD CARE FACILITY RECORD CONTACT:
Ellen Linen, Office of Child Care Licensing
4417 Lancaster Pike Building #18, Wilmington De 19805

YOU MAY ALSO VIEW SUBSTANTIATED COMPLIANTS AND CONPLIANCE REVIEW HISTORIES FOR THE PAST THREE YEAR BY VISITING
http://www.apex01.kids.delaware.gov:7777/occl/

I acknowledge receiving this notice as part of the application packet.

Parent's/Guardian's Signature _____ Date _____

PARENTS PERMISSION TO WATCH TV/DIGITAL VIDEO

Children over the age of 2 years old may have an educational movie or program incorporated into their curriculum. Videos shown will be age appropriate and not exceed one hour in length.

I hereby authorize my child to watch educational videos.

Parent's/Guardian's Signature _____ Date _____

PARENTS PERMISSION TO WATCH TV/DIGITAL VIDEO

Children over the age of 2 years old will have the opportunity to occasionally play educational games on the computer. Children will be closely to ensure that age appropriate and educational websites are being viewed while using the internet. Computer use time will not exceed one hour in length.

I hereby authorize my child to use the computer.

Parent's/Guardian's Signature _____ Date _____

RECIEPT OF PARENT HANDBOOK

I CERTIFY THAT I HAVE RECEIVED INFORMATION REGARDING THE CENTER'S POLICY ON THE FOLLOWING TOPICS:
A typical daily schedule, positive behavior management techniques, routine and emergency health care, health exclusions, prevention of communicable diseases, food and nutrition, procedures for releasing children, reporting of accidents, injuries and critical incidents, mandatory reporting of child abuse and neglect, developmental and educational goals, compliance, and transportation if provided.

Parent's/Guardian's Signature _____ Date _____

TRANSPORTATION PERMISSION

I hereby give permission for my child to be transported by A Leap of Faith CDC's authorized driver.

Parent's/Guardian's Signature

Please list any special needs or concerns which might require special attention during transportation and instructions on how to handle the special need or concern. This information will be carried with the vehicle operator named above.

Parent's/Guardian's Signature _____ Date _____