

Admission Information

Child's Name: _____ Date of Birth: ____/____/____ Ethnicity: _____
 Child's Home Address: _____ Zip Code _____ Home Phone #: _____
 Date of Admission: ____/____/____ Date of Withdrawal: ____/____/____ Days child will be in care: _____
 Hours child will be in care: _____
 Parent/Guardian Name: _____ Address (if different from Child's): _____
Please list additional telephone numbers where parents/guardian may be reached while child will be in care:
 Mother's Cell Ph#: _____ Father's Cell Ph#: _____ Guardian's Cell Ph#: _____

Mother's Work/Training:

Employer: _____ Work # _____
 Address: _____
 Wk Schedule: Days _____ Hours _____

Father's Work/Training:

Employer: _____ Work # _____
 Address: _____
 Wk Schedule: Days _____ Hours _____

Family Status:

Parents live together Parent absent or deceased Parents separated Other, Specify _____

Give the name, address and phone number of persons to call in case of an emergency if parents/guardian cannot be reached:

Name	Address	Phone #	Relationship

I hereby authorize Greenwood Molina Children's Center (GMCC) to allow my child to leave **ONLY** with the following persons*. Please list name, telephone number & relationship to child for each.

NAME	PHONE #	RELATIONSHIP	NAME	PHONE #	RELATIONSHIP

Please designate a Code Word to be given to authorized persons to pick up your child(ren): _____
 *Children will be released **ONLY** to a parent or a person designated by the parent/guardian after verification of I.D.

CHECK ALL THAT APPLY:

1. TRANSPORTATION:
 I hereby give do not give – consent for my child to be transported and supervised by GMCC employees.
 for emergency care on field trips to and from home to and from school
2. FIELD TRIPS:
 I hereby give do not give – consent for my child to participate in Field Trips:
 Comments: _____
3. WATER ACTIVITIES:
 I hereby give do not give – consent for my child to participate in Water Activities:
 sprinkler play splashing/wading pools swimming pools water table play

SCHOOL AGE CHILDREN:

My child attends the following school: _____
Name & Address of School School Phone #

CHECK ALL THAT APPLY:

- His / her immunization record is on file at the school and all required immunizations and/or Tuberculosis test are current.
 Vision and Hearing screening records are also on file.
- My child has permission to:
 ride a bus, walk to and from school, be released to the care of his/her sibling(s) under 18 years old.
 Name & age of sibling(s): _____

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event I can't be reached to make arrangements for emergency medical care, I authorize the person in charge (GMCC Employee) to take my child to:

Name of Physician: _____ Address: _____ Ph#: _____
Name of Hospital: _____ Address: _____ Ph#: _____

I give consent for the facility to secure any and all necessary emergency medical care for my child.

Signature - Parent or Legal Guardian

Date

List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregiver's should be aware of:

ADMISSION REQUIREMENT: If your child does not attend pre-kindergarten or school away from the child-care operation, one of the following must be presented when your child is admitted to the child-care operation or within one week of admission.

Please check only one option:

- 1. HEALTH-CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he / she is physically able to take part in the day care program.

Health Care Professional's Signature Date

- 2. A signed and dated copy of a health care professional's statement is attached.

- 3. PARENT'S STATEMENT: My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and will submit it to the child-care operation.

Name and address of health care professional:

Signature - Parent or Legal Guardian *Date*

- 4. *Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.*

*Any time changes occur in the above information, I will notify GMCC **immediately**. I understand that I must also provide GMCC a copy of my Photo I.D. & Social Security Card for use as proof of identification and for verification.*

Signature - Parent or Legal Guardian

Date

TO BE REVIEWED EVERY 6 MONTHS

I have reviewed the above stated information and the following changes have been made: *(Write "none" if no changes were made.)*

Parent/Guardian Signature _____ Date _____

I have reviewed the above stated information and the following changes have been made: *(Write "none" if no changes were made.)*

Parent/Guardian Signature _____ Date _____