

COMMUNITY CHRISTIAN CHILD DEVELOPMENT CENTER

Enrollment Application



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Date _____ Enrollment Date _____

Child's Name _____ Age _____ Birthday _____

Child likes to be called _____ Sex _____ SS# _____

Child Care Request (check one): part time _____ full time _____ summer program _____

Payment method (check one): Private _____ Subsidized _____

Child's Father _____ SS# _____

Address _____ City/State/Zip _____

Living in home with Child? _____ Born Again Christian? _____

Employer _____ Position _____

Home Phone _____ Work Phone _____

E-Mail Address _____ Cell Phone _____

Child's Mother _____ SS# _____

Address _____ City/State/Zip _____

Living in home with Child? _____ Born Again Christian? _____

Employer _____ Position _____

Home Phone _____ Work Phone _____

E-Mail Address _____ Cell Phone _____

Marital Status (check one): Married _____ Single _____ Divorce _____ Separated _____ Living Together _____

If divorced, what are the custody/ visitation arrangements?

(legal documentation is required upon enrollment)

Special instruction for parent(s) contact: _____

REFERENCE SOURCE

How did you hear about our center _____

List other members in household

Name _____	Relationship _____	Age _____
Name _____	Relationship _____	Age _____
Name _____	Relationship _____	Age _____
Name _____	Relationship _____	Age _____

Describe child's play experiences: Outdoors _____

With other children _____

Favorite game _____ Favorite Toy _____

Has he/she had experience with: (check one): Play dough ___ Scissors ___ Easel ___ Painting ___ Finger
Painting ___ Blocks _____ Sand ___ Water Play ___

How does child interact with: Parents? _____

Brother and/or Sister _____

Favorite Playmate is: (check) Older _____ Younger _____ Same Age _____

As a rule is your child's appetite: Good? ___ Fair? ___ Poor ___.

Can child feed self completely? Yes ___ No ___

Has he/she been cared for by anyone other than parents? _____ By whom? _____

Where: In own home? _____ Daycare? _____ Sitter's home? _____

Does child have any special challenges? _____

Fears? _____ Eating? _____ Health? _____

If yes, please explain _____

Is there anything in your child's developmental history we should be aware of? _____

MEDICAL PERMISSION

I hereby give my permission to CC Child Development Center to call a doctor or EMS for medical or surgical care for my child should an emergency arise. In the event that emergency medical care becomes necessary I give the staff permission to use their best judgment to make those decisions that have to be immediately made, (if deemed necessary by the physician on duty). It is understood that all efforts to contact the parents, emergency contact person(s) and/or child's physician will be made prior to any action on the staff's behalf.

Parent/Guardian Signature

Date

I agree that the operator may authorize the physician of his /her choice to provide emergency care in the event that neither I nor my emergency contact person can be contacted. The family physician can be contacted immediately.

Signature of Parent _____ Date _____

I, as the operator, do agree that transportation to an appropriate medical resource in the event of an emergency is provided. In an emergency situation, other children in the facility will be supervised by a responsible adult. We will not administer any drug or medication without specific instruction 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 _____ Date _____

CHILDREN'S MEDICAL REPORT

A. Medical History (may be completed by parent)

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

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

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

4. Any previous hospitalizations or operations? Yes _____ No _____ If yes when and for what? _____

5. Any history of significant previous diseases or recurrent illness? Diabetes? Yes _____ No _____
Convulsions? Yes _____ No _____ Heart Trouble? Yes _____ No _____
If others, what/when? _____

6. Does the child have any physical disabilities? Yes _____ No _____

If yes, please describe: _____

Any mental disabilities? Yes _____ No _____

If yes, please describe: _____

Signature of Parent or Guardian _____ Date _____

B. Physical Examination:

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

Date of Examination _____ Height _____ Weight _____

Head _____ Eyes _____ Ears _____ Nose _____ Teeth _____ Throat _____ Neck _____ Heart _____ Chest _____

Abd/GU _____ Ext _____ Neurological System _____ Skin _____

Result of Tuberculin Test: Type _____ Date _____ Normal _____ Abnormal _____

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

Signature of authorized examiner/title _____

Date _____

Office Address (may use office stamp) Phone _____

EMERGENCY CONTACT

Person(s) authorized to act for parents in case of an emergency:

Name _____ Relationship _____
Home Phone _____ Work Phone _____ Cell Phone _____
Name _____ Relationship _____
Home Phone _____ Work Phone _____ Cell Phone _____
Name _____ Relationship _____
Home Phone _____ Work Phone _____ Cell Phone _____

PHOTO RELEASE

Picture taken of my child in activity groups at CC Child Development Center may be used for the purpose of publicity (i.e. newspaper, television, posters or in picture presentations of the center's activities).

Parent/Guardian Signature Date

CHILD RELEASE

I give my consent for my child _____ to be released to the following persons only, in the event I am unable to pick him/her personally.

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

EMERGENCY CARE INFORMATION

Name of child's doctor _____ Office Phone _____
Name of child's dentist _____ Office Phone _____
Hospital preference _____ Office Phone _____
Insurance Carrier _____ Policy Number _____

LIST ANY KNOWN ALLERGIES: _____

Community Christian Member? Yes ____ No ____ How Long? _____
If no, which denomination are you affiliated? _____
Does the child live in a Christian home? Yes _____ No _____
Is the child a born again Christian? Yes _____ No _____
How often does the child attend church? _____