

**CHILD'S APPLICATION FOR CHILD CARE – Page 1**  
*To be completed and placed on file prior to enrollment*

Name of Child \_\_\_\_\_ Birth date \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_ Race: \_\_\_\_\_

**INFORMATION ABOUT THE FAMILY:**

*Both parents are allowed to pick up the child unless custody court papers are on file in the school office*

Allowed to pick up child       Emergency Contact

Father/Guardian's Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ Zip Code \_\_\_\_\_  
Email address: \_\_\_\_\_

Company Name \_\_\_\_\_ Job Title: \_\_\_\_\_  
Business Phone \_\_\_\_\_ Cell Number: \_\_\_\_\_  
Phone \_\_\_\_\_

Allowed to pick up child       Emergency Contact

Mother/Guardian: \_\_\_\_\_ Home \_\_\_\_\_  
Address \_\_\_\_\_ Name \_\_\_\_\_ Zip Code \_\_\_\_\_  
Email address: \_\_\_\_\_

Company \_\_\_\_\_ Job Title: \_\_\_\_\_  
Business Phone \_\_\_\_\_ Cell Number: \_\_\_\_\_

*\*Court filed Custody papers must be on file in the school office to eliminate one of the parents from pick up or emergency contact*

Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

**INFORMATION ABOUT YOUR CHILD:**

Does your child have any known allergies: No \_\_\_\_\_ Yes \_\_\_\_\_

Explain: \_\_\_\_\_

Explain: \_\_\_\_\_

Medical

Does your child have any chronic illnesses/conditions: No \_\_\_\_\_ Yes \_\_\_\_\_

(Emergency Asthma or \_\_\_\_\_ Plans must be completed and medication provide)

Please give any information concerning your child, which will be helpful in his/her experience in a group setting (such as play, eating and sleeping habits, special fears, special likes or dislikes).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**EMERGENCY STUDENT CARE INFORMATION:**

Name of child's doctor \_\_\_\_\_ Office Phone \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_

Name of child's dentist \_\_\_\_\_ Office Phone \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_

Hospital preference:	Pardee	Park Ridge	Mission
Circle one choice only	696-1000	681-2300	213-1111

**EMERGENCY CARE/ PICK-UP INFORMATION** (People authorized to pick-up my child from school. Must be 18 years old and have a valid driver's license)

If neither father nor mother (or guardian) can be contacted, the following people have my permission to pick-up my child from school and/or give instructions about their care.

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_

Relationship to child: family relation      friend      sibling      grandparent      step-parent

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_

Relationship to child: family relation      friend      sibling      grandparent      step-parent

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_

Relationship to child: family relation      friend      sibling      grandparent      step-parent

If you cannot pick up your child, please give the names of persons in addition to the emergency care/pick-up information listed above to whom the child can be released: (Please provide phone numbers)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Notification of Referral Policy**

Many times, St. James staff will contact Child Care experts to come in and give us feedback, suggestions, strategies and techniques to try with certain situation that may arise within a class- group setting. I give my consent for my child to be observed and/or referred to the Child Care Health Consultant, CCR&R Consultants, Park Ridge Prep Consultants, St. James Library Project Volunteer, Once upon a Time Literacy Volunteers, Special Readers and any other Child Care Resources that may be deemed necessary by St. James School for Little Folks. I give these individuals permission to contact my child's medical care provider or service provider to request or give information, which might benefit my child in his/her development and health. Should an individualized plan be deemed necessary for my child, the appropriate party for discussion will contact me before any changes are made to my child's normal routine as a result of these group classroom experiences? All information gained is confidential and private.

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 and/or accompany your child to an appropriate medical facility 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 attending 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)