

White Rock Baptist Church
 Child's Application For Child Care
 (To be completed and placed on file prior to enrollment)

| | | | |
|----------------------------|--|-------------------|-----------------|
| Name of Child | Last Name: _____ | First Name: _____ | Nickname: _____ |
| Birth date | Month: _____ | Date: _____ | Year: _____ |
| Insurance | Insurance Carrier: _____ Policy #: _____ | | |
| Parents | Father/Guardian's Name: _____ Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____ Address: _____ Where Employed: _____ | | |
| | Mother/Guardian's Name: _____ Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____ Address: _____ Where Employed: _____ | | |
| Child's Health | Does your child have any known allergies: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain: Provide a list of medications that we would be required to administer: List your child's play, eating and sleeping habits, special fears, special likes/dislikes: | | |
| Emergency Care Information | Name of child's doctor: _____ Office Phone #: _____ Address: _____ Name of child's dentist: _____ Office Phone #: _____ Hospital Preference: _____ Phone #: _____ If neither father nor mother (or guardian) can be contacted call: Name: _____ Relationship: _____ Phone #: _____ Name: _____ Relationship: _____ Phone #: _____ | | |
| Pick-Up Person | Please give the names of persons to whom your child can be released in your absence: Name: _____ Relationship: _____ Name: _____ Relationship: _____ Name: _____ Relationship: _____ | | |
| Authorization | 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 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. Signature of Operator: _____ Date: _____ | | |

White Rock Baptist Church
Child Development Center School Application

Date of Application: _____

How did you hear about WRBC Child Development Center? _____

Child's Name: _____ DOB _____ Sex _____

Home Address: _____

Email Address: _____

Parent's Name _____ Parent's Name _____

Home Phone # _____ Home Phone # _____

Work Phone # _____ Work Phone # _____

Employer/Student @ _____ Employer/Student @ _____

Position Title _____ Position Title _____

Average Yearly Household Income _____ Number in household _____

Child's previous childcare arrangements/school: _____

Contact Name and Phone # _____

Parents are: Married Divorced Separated Single Unmarried living together

The child resides with: _____ Number of siblings: _____

Name of sibling: _____ DOB: _____

Name of sibling: _____ DOB: _____

Name of sibling: _____ DOB: _____

Name of sibling: _____ DOB: _____

Does your child have any medical concerns, allergies, disabilities, or receive special services?

If so, agency involved and contact person: _____

Is your child toilet trained? Yes No

Enrollment Request Date: _____ Application Received: _____

Registration & Activity Fee Paid Start Date _____ Wait Listed For _____