



COOPERATIVE CHILDCARE

1808 Woodmont Blvd Nashville, Tennessee 37215 297-9256
Enrollment Application

Family Information:

Last Name _____		Child's Name _____	
Address _____		City _____	State _____ Zip Code _____
Home Phone _____		Other Phone _____	
Mother's Name _____		Father's Name _____	
Employer: _____		Employer: _____	
Work Phone: _____		Work Phone: _____	
Cell Phone: _____		Cell Phone: _____	
Email: _____		Email: _____	

Emergency Information:

_____	_____
Dentist	Pediatrician
_____	_____
Dentist Telephone Number	Pediatrician Telephone Number

Hospital Preference	

Emergency Contacts and Persons allowed to pick up your child:

_____	_____
1 st Contact Person/Relationship	1 st Contact Telephone Number
_____	_____
2 nd Contact Person/Relationship	2 nd Contact Telephone Number
_____	_____
3 rd Contact Person/Relationship	3 rd Contact Telephone Number

Special Custody information:

Please list any special Custody information and instructions: _____

Child Profile

Date _____

Child's Name _____ **Date of Birth:** _____

Physical Issues: Please answer "yes" or "no" to the following questions

- _____ there were problems during pregnancy/birth of child
- _____ the birth weight under 5 ½ pounds
- _____ child has been hospitalized over night. Reason: _____
- _____ child taking medications at this time. Medicines: _____
- _____ child has had reaction to immunizations.
- _____ child has had asthma or wheezing. When: _____
- _____ child has speech/hearing problems Describe: _____
- _____ child has had more than 2 ear infections in one year
- _____ child has had a bladder or kidney infection
- _____ child has had seizures, fits, or shaking spells? When: _____
- _____ child has been diagnosed with a heart murmur
- _____ child is on a heart monitor
- _____ child is able to play as hard as other children
- _____ child has ever had a bumpy, swollen reaction to a TB skin test
- _____ child has been around a person with TB
- _____ child is a hemophiliac (free bleeder)
- _____ child has tubes in their ears
- _____ child is participating in classes for specific development issues. Describe the classes currently enrolled in for these issues. _____

- _____ child generally gets along with their peers and adults
- _____ child is usually happy
- _____ child has the following allergies (food, medicines, insect bites, etc.) _____

_____ child has attended other preschool. Dates and where attended: _____

_____ child has the following fears: _____

Child last saw the pediatrician on _____.

Family Environment:

Child has own room Yes or No

Other adults living in the home: _____

Siblings and their ages: _____

Special Instructions:

Please describe in detail any additional information about your child/family that will help us care for your child. (IE: potty training, sleep habits, physical/mental/emotional issues, special needs, etc.) _____

Parental Consent

Child's Name _____

I have toured Cooperative Child Care and have been informed of the services and programs offered. I have read the Parent Handbook and agree to the policies contained therein. I have received a copy of the DHS summary sheet & guidelines for meals.

_____ (initial, please)

Dangerous Situation Release

I understand that CCC staff are not permitted to release my child into what they consider to be a dangerous situation that threatens my child's safety.

Parent signature _____

Date _____

Authorization for Medical Treatment

This shall serve as full authorization and approval by the undersigned, as parent, guardian, next of kin, or legal representative of _____, for such emergency medical care and treatment as is the discretion of Cooperative Child Care as needed for said child or children, whether administered by staff personnel at Cooperative Child Care or by doctors, nurses, and hospital staff personnel. Furthermore, the undersigned releases Cooperative Child Care and its staff personnel from liability of any and all claims arising out of medical care, custody and supervision delivered by physicians or other qualified medical personnel.

Signature of Parent or Guardian _____

Date _____

Neosporin

My child has permission to have the staff at CCC apply Neosporin to any cut or scrap. _____ (initial please)

Permission to Photograph: Please check all that you agree with.

___ you do have my permission to submit a photograph of my child to be used in a publication

___ you do have my permission to use my child's photograph in the classroom

___ you do **NOT** have my permission to submit my child's photograph to be used in a publication.

___ you do **NOT** have permission to use my child's photograph in the classroom.

___ (initial, please)

Field Trip Permission

_____ has my permission to travel to and from points of interest on excursions connected with the program, under the supervision of a staff member and after written notification of the dates, time and the location of the excursion. It is understood that the supervising staff member will exercise all reasonable care for the safety of my child and I agree that I will not hold Cooperative Child Care responsible for injury or accident to my child if said care is established on the part of the staff accompanying my child.

Parent/Guardian Signature _____

Date _____

Bug Spray

OFF Skintastic Family Formula Insect Repellent: Contents: Ethyl Alcohol, N, N-Diethyl-Toluamide, Fragrance, Aloe, 7% Deet

___ My child has permission to have **Off Skintastic Family Formula Insect Repellent** applied by CCC staff

___ My child **DOES NOT** have permission to have **Off Skintastic Family Formula Insect Repellent** applied by CCC staff.

Parent's Name (please print) _____

Parent's Signature _____

Date _____

Dear Parent or Guardian:

This form is provided to you to leave with those responsible for your child in your absence. If your child needs emergency medical treatment during your absence, the completed form should be presented to the attending physician. Individual hospitals and medical personnel may require additional authorization. Please return this form to Cooperative Child Care and report any changes to the Executive Director.

Child's Name _____ Birth Date _____
Address _____
Father's name _____ Place of employment _____
Home Phone _____ Work Phone _____
Mother's name _____ Place of employment _____
Home Phone _____ Work Phone _____
Child's physician _____
Office Phone _____ Other Phone _____
Preferred surgeon (if any) _____
Office Phone _____ Other Phone _____
List any respiratory illnesses or medication allergies the child has _____

List any medications the child is now taking _____

Date of last tetanus shot ____/____/____ Blood type _____
Number at which parent can be reached _____
Friend or relative that can be reached _____ Phone # _____
Insurance company _____ Policy number _____

Authorization

I hereby authorize the treatment of my minor child _____
in the event of an emergency situation occurring in my absence. This authorization extends to any hospital and both physician and nursing personnel within the hospital. I release from medical responsibility and liability the hospital medical authorities and physicians for performing medical procedures acting on the authority of this medical treatment consent form which are deemed necessary for my minor child. If I cannot be reached in case of an emergency, please allow Cooperative Child Care to act in my behalf.

Signature of Parent or Legal Guardian Date

Witness Date