|  |
| --- |
| **Chapel Hill Cooperative Preschool****106 Purefoy Road Chapel Hill NC 27516****919-942-3955** |

**Date you our child to enter:** ASAP\_\_\_\_\_\_\_\_\_ Summer\_\_\_\_\_\_\_\_\_\_\_\_ Fall\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Day Length: ½ Day\_\_\_\_\_\_ ¾ Day\_\_\_\_\_\_\_ Full Day\_\_\_\_\_\_\_

Part Time: MWF / TTH

**CHILD’S INFORMATION**

Full Name: Last First Middle Name called

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child's Physical Address: ­­­­­­­

Was the child born in another country: Y N If yes, which one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY INFORMATION**

Child lives with:

Parent 1’s Name Home Phone Address (if different from child’s) Zip Code Work Phone Cell Phone

Email \_\_­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s 2’s Name Home Phone Address (if different from child’s) Zip Code Work Phone Cell Phone

Email \_\_­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# CONTACTS

Child will be released only to the parents/guardians listed above. The child can also be released to the following individuals, as authorized by the person who signs this application. In the event of an emergency, if the parents/guardians cannot be reached, the facility has permission to contact the following individuals.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Name | Relationship | Address | Phone Number |  |
| Name | Relationship | Address | Phone Number |  |
|  | Name | Relationship | Address | Phone Number |  |

# HEALTH CARE NEEDS:

*For any child with health care needs such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child’s parent or health care professional. Is there a medical action plan attached? Yes No*

List any allergies and the symptoms and type of response required for allergic reactions. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any health care needs or concerns, symptoms of and type of response for these health care needs or concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any particular fears or unique behavior characteristics the child has: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any types of medication taken for health care needs Share any other information that has a direct bearing on assuring safe medical treatment for your child

# EMERGENCY MEDICAL CARE INFORMATION:

Name of health care professional \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hospital preference\_\_\_\_\_\_\_\_

I, as the parent/guardian, authorize the center to obtain medical attention for my child in an emergency.

Signature of Parent/Guardian 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 Administrator Date

**This is a very creative/messy school. We encourage the children to learn and grow through active participation and exploration. We love to play in the mud. We go outside each day regardless of the heat and cold. We finger paint frequently and have a great time with water play.**

Has your child had previous experience in a child care situation? Name and location of facility?

Do you understand that this is a cooperative preschool and that you will be required to give time to volunteer with the preschool?

Why do you want to be a part of a cooperative preschool?

What are the aspects of group care that concern you the most?

What do you hope our center can provide for your child?

Are there any restrictions (religious, philosophical, dietary) you would wish to observe at school?

Does your child take a nap?

Please give any information concerning your child that will be helpful in his/her experiences with group living (such as play, eating and sleeping habits, special fears special likes and special dislikes)

Other children in the family:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Attended CHCP: \_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Attended CHCP: \_\_\_\_\_\_\_\_\_\_\_

Application Fee Received:

Deposit Fee Received:

Registration Fee Received: