kidsCARE academy

Internal Use Only
Start Date: _____
Immunization Records: _____
Tuition Express: _____
Registration Fee:_____

Application Form

Child's Name: _____Child's Date of Birth _____/_____/_____ Age: ___

Child's Gender: ☐ Male ☐ Female Program Applying for: ☐ 2 day ☐ 3 day ☐ 5 day

Mailing Address _____City _____ State: ____ Zip Code _____

Mom's Name _____Cell Phone _____

Dad's Name _____ Cell Phone _____

Mom's Email (please print) _____

Dad's Email (please print) _____

Has your child attended preschool before? ☐ Yes ☐ NO If yes, which Preschool _____

Two individuals other than the child's parents that can obtain emergency medical treatment for the child.

1. Full Name _____ Relationship _____

   Contact number _____

2. Full Name _____ Relationship _____

   Contact number _____

List anyone other than the contacts above that is permitted to pick up the child.

Full Name _____ Contact Number_____

Full Name _____ Contact Number_____

Full Name _____ Contact Number_____

Full Name _____ Contact Number_____

Health Information: (please also include a copy of the child's most recent shot certificate)

Family Physician _____ Contact Number _____

Preferred Emergency Care Provider _____

Dental Care Provider _____ Contact Number _____

Health Insurance Provider _____Policy Holder Name and D.O.B._____

Insurance ID _____

My child has the following health conditions such as allergies, asthma, diabetes etc.

_____

Signature: _____ Date _____