



## **CHILD CARE APPLICATION FOR ENROLLMENT IN SPECIALIZED CHILD CARE FACILITIES FOR MILDLY ILL CHILDREN**

### **Student Information:**

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Enrollment: \_\_\_\_\_

Full Name: \_\_\_\_\_  
Last First Middle Nickname

Child's Physical Address: \_\_\_\_\_

Primary Hours of Care: From: \_\_\_\_\_ To: \_\_\_\_\_

Days of the Week in Care: ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ Sa ☐ Su

Meals Typically Served While in Care: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper

### **Family Information:**

Child's Lives With: \_\_\_\_\_

Parent's/  
Guardian's  
Name: \_\_\_\_\_

Parent's/  
Guardian's  
Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Custody: ☐ Mother ☐ Father ☐ Both ☐ Other (specify): \_\_\_\_\_

**Medical Information:** I hereby grant permission for the staff of this facility to contact the following medical personnel to obtain emergency medical care if warranted.

Doctor: \_\_\_\_\_ Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Doctor: \_\_\_\_\_ Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

Present Illness: \_\_\_\_\_

Allergies/Reaction: \_\_\_\_\_

Present Medications and Dosages: \_\_\_\_\_

Current Diet: \_\_\_\_\_

Diapering Requirement (if applicable): \_\_\_\_\_



Symptoms Requiring Parent or Health Care Provider Notification/Special Instructions:

**Past Medical History:**

Other illnesses or Childhood Diseases: \_\_\_\_\_

Past Medications: \_\_\_\_\_

**Emergency Contacts:** Child will be released only to the custodial parent(s) or legal guardian(s) and the persons listed below. The following people will also be contacted and are authorized to remove the child from the facility in case of illness, accident or emergency, if for some reason, the custodial parent(s) or legal guardian(s) cannot be reached:

Name	Address	Work Phone	Cell/Home Phone
Name	Address	Work Phone	Cell/Home Phone
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**Helpful Information About Child:**

- Section 7.3 of the Child Care Facility Handbook requires that parents receive a copy of the Child Care Facility Brochure entitled "Know Your Child Care Facility" (CF/PI 175-24) [also available on-line at <https://eds.myflfamilies.com/DCFFormsInternet/Search/OpenDCFForm.aspx?FormId=860>].
- Section 7.3, C.3, of the Child Care Facility Handbook requires that parents are provided food and nutrition policies used by the child care facility].
- Rule 65C-25.003(14)(b), Florida Administrative Code, requires that parents receive copies of the facility's admission policy; infection control procedures; daily care procedures; plan for the care of children exhibiting worsening symptoms, and referral for medical evaluations, including a listing of the symptoms; policy and procedure for staff communication with parents and health providers; and, discipline and expulsion policies.

Your signature below indicates that you have received the above items and that the information on this enrollment form is complete and accurate. I hereby grant permission for the staff of this facility to have access to my child's records.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date