

Wee Know School
3325 Hwy 83
Hartland, WI 53029

ENROLLMENT FORM

Classroom _____
School Year _____
Date Entered _____

Child's Name _____ Date of Birth _____ Sex _____

Address _____ City _____ Zip _____

Nickname _____ Elementary school he/she will attend _____

Previous group experience _____

FATHER'S NAME: _____

e-mail address _____

Address (if not same as child) _____

MOTHER'S NAME: _____

e-mail address _____

Address (if not same as child) _____

Home phone # _____

Work phone # _____

Cell phone # _____

Pager _____

Employer _____

Profession _____

Home phone # _____

Work phone # _____

Cell phone # _____

Pager _____

Employer _____

Profession _____

Marital Status of Parents _____

Child resides with _____

NAMES & BIRTHDATES OF SIBLINGS:

EMERGENCY CONTACT : *(if father or mother cannot be reached)*

| <u>NAME</u> | <u>Relationship to Child</u> | <u>Phone No.</u> | <u>Authorized to pick up</u> |
|-------------|------------------------------|------------------|------------------------------|
| 1. _____ | _____ | _____ | <u>yes</u> no |
| 2. _____ | _____ | _____ | <u>yes</u> no |

PERSONS AUTHORIZED TO PICK UP MY CHILD: *(include parents)*

| <u>NAME</u> | <u>Relationship to child</u> | <u>NAME</u> | <u>Relationship to child</u> |
|-------------|------------------------------|-------------|------------------------------|
| 1. _____ | _____ | 4. _____ | _____ |
| 2. _____ | _____ | 5. _____ | _____ |
| 3. _____ | _____ | 6. _____ | _____ |

AUTHORIZATION

- YES NO I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
- YES NO I give my permission for my child to be photographed during play at Wee Know School to be used occasionally for marketing and publicity purposes.
- YES NO I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin Rules for Licensing Care Centers (available in office).
- YES NO I give my permission for my child to participate in field trips and other activities during operating hours with advance notice.
- YES NO My child has an IEP (Individualized Special Education Plan). If yes, please indicate school district involved: _____.

HEALTH HISTORY & EMERGENCY CARE PLAN

1. Check any special medical conditions that your child may have.

- Asthma
- Cerebral palsy / motor disorder
- Diabetes
- Epilepsy / seizure disorder
- Heart Problem
- Gastrointestinal or feeding concerns including special diet and supplements
- Emotional/behavior disorder including ADD or ADHD
- Other condition(s) requiring special care - Specify

Food allergies - Specify food(s).

Non-food allergies - Specify

2. Triggers that may cause problems/Signs or symptoms to watch for - Specify

3. When to call parents regarding symptoms or failure to respond to treatment:

4. Steps the child care provider should follow. a.

b.

c.

(If medications are necessary, a copy of the CFS-59, Authorization to Administer Medications, should be attached to this form.)

5. When to consider that the condition requires emergency medical care or reassessment.

6. Additional information that may be helpful to child care provider.

7. PHYSICIAN'S NAME _____ ADDRESS _____
TELEPHONE # _____ CITY _____

SIGNATURE (Parent or Guardian) _____ **Date signed** _____