Revised 8/6/14

The Center School-Age Program
Lake County Schools
2014-2015 Application Form

Date Completed	**OFFICE USE ONLY** Enrollment Date ______________ Entry Date ______________

Child Information

Last Name	First Name	Middle Name	Nickname

Date of Birth	Birthplace	☐ Male ☐ Female	Lives with: ☐ Mom ☐ Dad ☐ Both ☐ Other ________

Mother Information

☐ In home ☐ Not in home	Name	Mailing Address

Date of Birth	Physical Address

Preferred daytime contact ☐ Home ☐ Work ☐ Cell	Home Phone	Cell or Message	Email Address

Employer	Address	Work Phone

If not in home, do we have permission to contact / mail?	☐ Yes ☐ No	Is there a court order affecting your child?	☐ Yes ☐ No	If yes, you must provide a copy Details of order-

Father Information

☐ In home ☐ Not in home	Name	Mailing Address

Date of Birth	Physical Address

Preferred daytime contact ☐ Home ☐ Work ☐ Cell	Home Phone	Cell or Message	Email Address

Employer	Address	Work Phone

If not in home, do we have permission to contact / mail?	☐ Yes ☐ No	Is there a court order affecting your child?	☐ Yes ☐ No	If yes, you must provide a copy Details of order-

Other Adult in Home: ☐ Guardian ☐ Step Parent or ☐ Live-in Partner Information (please check one)

Name	Physical Address

Date of Birth		Mailing Address

Preferred daytime contact ☐ Home ☐ Work ☐ Cell	Home Phone	Cell or Message	Email Address

Employer	Address	Work Phone

Other People in Your Home (please do not list child or parents listed above)

Name	Relationship	Date of Birth	Name	Relationship	Date of Birth

Emergency Contact and Permission to Release (do not list parents/guardians - must be over 18)

Name	Address	Relationship
#1 Phone	#2 Phone	Note-
Name	Address	Relationship
#1 Phone	#2 Phone	Note-
Name	Address	Relationship
#1 Phone	#2 Phone	Note-

Medical Treatment Authorization

I authorize staff members of The Center Early Childhood Programs to arrange for medical or surgical care for my child named above, and give consent for care and/or treatment in the event of an emergency. Staff members may use their judgment in deciding what an emergency is, and may request the services of our doctor named on the Health Information form or another if he/she is unavailable, and call the hospital, and/or an ambulance. I understand that an attempt will be made to reach me and/or the emergency contacts provided to The Center, but contact is not necessary for the above consent to be in effect. A copy of this form will be presented as medical treatment authorization, and will be considered valid as the original. This consent will be in effect until withdrawn in writing by the person(s) signing. I accept responsibility for related expenses incurred, which are not the responsibility of The Center Early Childhood Programs or its employees.

Information Release

I give permission for The Center Early Childhood Programs to exchange information with the following community partners for the purpose of providing the best services for my child and family. This authorization will continue in force until revoked by me in writing, and a copy or fax shall serve in its stead. This includes permission to copy, release, or discuss information with the purpose of facilitating interagency communication in providing services to myself and my family.

• All programs operating at Margaret J. Pitts School	• West Central Mental Health
• Lake County Department of Human Services	• Disabilities Services Provider/Coordinator
• My child's medical care provider	• Family Literacy Program - Lake County Schools
• Lake County Public Health Agency	• Other-

Photo and Video Release

☐ Yes ☐ No	I authorize The Center Early Childhood Programs to photograph or permit photographs to be taken of my child named above, and for the filming of video. The photos/video may be posted in The Center, published in the newsletter or news media, or used in promotional materials for these programs.

Transportation Permission

☐ Yes ☐ No	Transportation- I give permission for my child named above to walk or be transported to activities, programs or field trips as part of participation in The Center School-Age Program.

Child Abuse Mandated Reporting

This is to inform you that all employees of The Center Early Childhood Programs are required by State Law to report all instances of suspected child abuse/neglect to the Lake County Department of Human Services. This agency will visit The Center to evaluate the circumstances, and if abuse or neglect is determined, and if the child is felt to be in danger of further abuse or neglect, the Department of Human Services will call the legal authorities and request that they take the child into protective custody, and they will notify you of the steps you must take.

Parent/Guardian Signature	Date

Child Health Information Form 1

Any Special Health Concerns

Please explain- ______________________________

____

____

Medication

Is your child currently taking any medication? □ Yes □ No
If "Yes" what type? ______________________________
Will the medicine be given during the child's time at school? □ Yes □ No (Doctors written authorization is needed)

Does your child have any allergies to any medication? □ Yes □ No
If yes please list ______________________________

Health History

Are there health problems or conditions that will limit activities or affect your child at school? □ Yes □ No
Please explain- ______________________________

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Allergies

List all food allergies- ______________________________
List any animal, fur, dust etc. allergies- ______________________________
□ Seasonal Allergies □ Bee Stings □ Insect Bites
Reactions to allergies (rash, itching, swelling, difficulty breathing, sneezing) ______________________________

Asthma

□ Yes □ No
Triggers______________________________
Will your child use an inhaler or nebulizer at school? □ Yes □ No

Sinus / Skin Problems

□ Eczema	□ Hives	□ Skin problems	□ Sinus problems

Diabetes

□ Yes □ No

Digestion Problems

□ Frequent Indigestion	□ Frequent Stomachaches	□ Frequent Vomiting

Bowel / Urinary Tract Problems

□ Frequent Diarrhea	□ Frequent Urination	□ Frequent Constipation	□ Painful Urination	□ Wears Diapers

Vision Problems

□ Difficulty Seeing	□ Headaches	□ Wears Glasses

Hearing Problems

□ Difficulty Hearing	□ Frequent Earaches	□ Tubes in Ears

Speech / Language Problems

□ Talked Late	□ Speech is Difficult to Understand	□ Other-

Other Conditions

□ Hyperactivity	□ Sudden Behavior Changes	□ Frequent Fevers	□ Anemia or Sickle Cell Anemia
□ Lack of Energy/Tired	□ Fearful	□ Fainting Spells	□ Bone, Joint or Muscle Injury or Disease
□ Accident Prone	□ Withdrawn	□ Seizure/Convulsions	

Disabilities

Does your child have a diagnosed disability? □ Yes □ No
What is the disability? ______________________________
Is child on an Individual Education Plan (IEP)? □ Yes □ No
What is the IEP for? ______________________________
Do you have any concerns about other children in your family who are not in The Center's Early Childhood Programs that may have developmental delays and/or disability concerns? □ Yes □ No
Would you like us to make a referral to Child Find to help you with your concerns? □ Yes □ No
If yes, Child's Name: ______________________________ Date of Birth ______________
Concern ______________________________ Date of Referral ______________

____

Child Health Information Form 2

Second Hand Smoke

Is your child exposed to second hand smoke? □ Yes □ No Parent's Initials ___________

Medical

Do you have medical coverage/insurance? □ Yes □ No
If "Yes" what type □ Medicaid ID# ______________________________
□ CHP+ ID# ______________________________
□ Private insurance Company Name & Policy #______________________
If "No", **please request an application** for Medicaid and CHP+. Assistance is available in completing this form.
Do you have a family doctor who provides your child's regular health care? □ Yes □ No
Dr. Name______________________________ Address______________________________
Phone Number__________________________

In case of an emergency, what hospital would you like your child transported to?
Hospital Name:__________________________ Address______________________________
Phone Number:__________________________

Is your child seeing a medical specialist for any reason? □ Yes □ No
If yes why: ____
Dr. Name______________________________ Address______________________________
Phone Number__________________________

Has your child had a serious injury, accident, been hospitalized or had surgery?______________________
____
Did mom or child have any health problems during pregnancy, or delivery, or stay in the hospital longer than normal?
____
Was your child born 3 weeks early or late? ______________What was the child's birth weight __________
Are you pregnant now? □ Yes □ No Due date? __________ Do you have prenatal care? □ Yes □ No

Dental

Do you have dental coverage/insurance? □ Yes (**please make a copy of the card**) □ No
If "Yes" what type □ Medicaid ID# ______________________________
□ CHP+ ID# ______________________________
□ Private insurance Company Name & Policy #______________________
Has your child been seen by a dentist before? □ Yes □ No
Dentist Name__________________ Address __________________ Phone Number__________
Is your child having pain now because of his/her teeth? □ Yes □ No
Does your child take a fluoride supplement? □ Yes □ No

Nutrition

Do you have any concerns about your child's eating? □ Yes □ No
Do you have any concerns about your child's weight? □ Yes □ No
Is your child on any special diet? (Diabetic, vegetarian, medical, religious or personal reason, etc.) □ Yes □ No
(A special diet statement from a medical authority and their recommendation is required to substitute any food served at The Center)

Parent/Guardian Signature	**Date**