A Little Miracle Child Development Center Inc. / A Baby's House
804 Pembroke Oak Grove Rd
Oak Grove, KY 4226

Application for Child Care

Start Date________________

Child's Full Name:____ Birth Date:______________

Address:____City:__________________Zip:___________

Child's School:____ Phone:_________________________

Parent or Guardian Information:

Guardian:____Relationship:________________

Home Phone:____________________________________ Cell Phone:__________________________________

Place of Employment:__________________________________ Work Phone:____________________________

Email:____ Military Unit:___________________________

Guardian:____Relationship:________________

Home Phone:____________________________________ Cell Phone:__________________________________

Place of Employment:__________________________________ Work Phone:____________________________

Email:____ Military Unit:___________________________

Siblings:

Name: ___________________________________ Birth Date: ___________

Name: ___________________________________ Birth Date: ___________

Name: ___________________________________ Birth Date: ___________

Name: ___________________________________ Birth Date: ___________

Communication:

Do you speak a language at home other than English? __________________

Are there any things that would help us communicate with your child? ___________________________________

____

____

Are there any cultural practices or Religious holidays you would like us to know about? ______________________

____

Medical Health History:

Chicken Pox____ Scarlet Fever____Diabetes____Malaria____HIV____Aids____Measles____Hepatitis____

Hepatitis A or B____Mumps____Asthma____Allergies:____

Has your child been diagnosed with any behavioral/mental illness? _____ If so, please explain: ________________

____

Does your child have frequent colds? _______Explain: ____

Has your child had any serious accidents? ____

Important health information that relates to your child: ____

____

Hospital Information/Name:____Phone:____________________

Child's Physician/Clinic:____Phone:____________________

Child's Dentist:____Phone:____________________

Briefly describe your child: Outgoing____Shy____Sensitive____Bossy____Temper____Defiant____Good sense of Humor____other____

What are your expectations for your child at this center? What ways can we help your child?________________

____

____

Authorization to pick up your child: Please give the names and numbers of people who you authorize to pick up your child if you are not available.

1. Name:____Phone:______________________________
   Relationship to the child:________________________
2. Name:____Phone:______________________________
   Relationship to the child:________________________
3. Name:____Phone:______________________________
   Relationship to the child:________________________
4. Name:____Phone:______________________________
   Relationship to the child:________________________
5. Name:____Phone:______________________________
   Relationship to the child:________________________

Person(s) NOT authorized to pick up your child:

1. Name:____Phone:______________________________
   Relationship to the child:________________________
2. Name:____Phone:______________________________
   Relationship to the child:________________________
3. Name:____Phone:______________________________
   Relationship to the child:________________________

Emergency Contact Information:

1. Name:____Phone:______________________________
   Relationship to the child:________________________
2. Name:____Phone:______________________________
   Relationship to the child:________________________
3. Name:____Phone:______________________________
   Relationship to the child:________________________

Medical Authorization Release:

I agree that A Little Miracle CDC may authorize emergency medical care, in the event neither the Family physician nor I can be contacted immediately.

Parent/Guardian Signature:____Date:__________________