



APPLICATION PACKET



FOR OFFICE USE ONLY

Date of Enrollment: _____

File Ingested By: _____



Personal Information



Full Name of Child: _____ Gender: _____

Name Child Responds To: _____ Date of Birth: _____

Address: _____

Grade in School: _____



Guardian 1's Name: _____ Place of Employment: _____

Home Phone: _____ Work Number: _____

Cell Number: _____

Address (if different from child's): _____

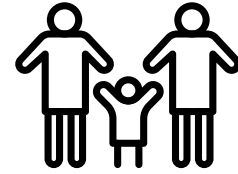
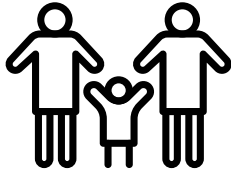


Guardian 2's Name: _____ Place of Employment: _____

Home Phone: _____ Work Number: _____

Cell Number: _____

Address (if different from child's): _____



Persons Authorized for Child Pick-Up (Aside from Parent(s)/Guardian(s))

1) Name: _____ Relationship: _____

Primary Phone #: _____ Work Phone #: _____

2) Name: _____ Relationship: _____

Primary Phone #: _____ Work Phone #: _____

Emergency Contact

1) Name: _____ Relationship: _____

Home Number: _____ Work/Cell Number: _____

2) Name: _____ Relationship: _____

Home Number: _____ Work/Cell Number: _____

3) Name: _____ Relationship: _____

Home Number: _____ Work/Cell Number: _____

Persons NOT Authorized to Pick Up Your Child



1) Name: _____ Relationship: _____

Home Number: _____ Work/Cell Number: _____

2) Name: _____ Relationship: _____

Home Number: _____ Work/Cell Number: _____

***Please note:** If there is a Custody Agreement, please give details below.

A COPY OF ANY CUSTODY AGREEMENT(S) MUST BE PROVIDED TO BRIGHTON HALL'S ADMINISTRATIVE STAFF.



Emergency Health Information

Doctor's Name/Clinic: _____ Phone Number: _____

Address: _____

Child's Care Card Number: _____

Dentist's Name/Clinic: _____ Phone Number: _____

Consent for Emergency Care

I, _____ (Guardian or Parent Name), consent for Brighton Hall's After-School Program staff to contact emergency services in the event that I cannot be reached during a health emergency with my child.

Signature of Parent: _____ Date: _____

Health Information (Please attach a separate sheet if necessary)

1) Regular medication (s) and reasons for (please list):

2) Allergies/Reactions and treatment (please list):

3) Any concerns/issues regarding your child's health (seizures, asthma, vision, hearing, etc) (please list and describe):



4) Any concerns regarding your child's development (behaviour, speech, language, mobility, etc) (please list and describe):

5) Please list any specific care instructions regarding #1-4:

6) Other health care professionals involved in your child's life (Occupational Therapist/Physical Treatment, etc) :

QUESTIONNAIRE

1) Has your child had previous Daycare experiences? If yes, how did he/she adapt?

2) What is/are your child's favorite toys/activities?



QUESTIONNAIRE CONTINUED

3) How does your child behave around other children (seeks others out, feels shy, etc)?

Emotional

1) How does your child react when left with unfamiliar people and/or in unfamiliar situations?

2) What suggestions do you have that would help staff ease your child's transition into the program?

Family Information

1) Please list the name(s) of the significant people in your child's life (siblings, grandparents, etc):

2) Primary language spoken at home:

3) Other languages spoken at home:



PERMISSION FORM ESCORTING CHILD to BRIGHTON HALL CAMPUS

I, the undersigned, hereby grant permission for the staff of Brighton Hall After School Care to escort my child, _____ (*child's name*), from Roosevelt Elementary school to Brighton Hall's campus.

I understand that the Brighton Hall After School Care staff will take all necessary precautions to ensure the safety and well-being of my child during this transition. I acknowledge that the staff members are trained to handle such activities and will follow all safety protocols as established by the daycare and the school.

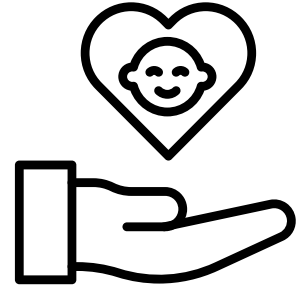
By signing the below, I confirm that I have read, understood, and agree to this arrangement.

Parent/Guardian Name: _____

Signature: _____

Date: _____





BILLING AUTHORIZATION

This information is treated confidential and will be kept on file only during the school year, charged as needed for tuition payments explicitly authorized by the cardholder.

Cardholder Name: _____

Cardholder Primary Phone #: _____

Cardholder Email: _____

PAYMENT INFORMATION

Card Type *(Please check one)*:

Visa ____ Mastercard ____ Amex ____ Discover ____

Card #: _____

Expiration: ____ / ____ CVC: ____

Billing Address: _____

Apt/Unit#: _____

City: _____ Zip Code: _____

Cardholder Signature: _____