Little Eagles Academy
Where Little Minds Soar

Application Date _____ **Date of Enrollment** _____ **Updated File Date** _____

CHILD APPLICATION

Name of Child _____
(Last) (First) (Middle) (Preferred Name)
Date of Birth _____ Gender _____

Address _____ City _____ Zip Code _____

Family Information

Father/Guardian Name _____
Address _____ Zip Code _____
Employer _____
Business Phone ( ) _____ Home Phone ( ) _____ Cell Phone ( ) _____

Mother/Guardian Name _____
Address _____ Zip Code _____
Employer _____
Business Phone ( )_____ Home Phone ( )_____ Cell Phone ( ) _____

Emergency Contacts/Child Release Information

Your child will only be released to those individuals listed in this section. Calling the center to add a name to the list for pickup is prohibited. Please list **all** individuals who may pick your child up.

Name: _____ Relationship: _____
Release: Yes___ No___ Home Phone: _____ Other Phone: _____

Name: _____ Relationship: _____
Release: Yes___ No___ Home Phone: _____ Other Phone: _____

Name: _____ Relationship: _____
Release: Yes___ No___ Home Phone: _____ Other Phone: _____

Name: _____ Relationship: _____
Release: Yes___ No___ Home Phone: _____ Other Phone: _____

Name: _____ Relationship: _____
Release: Yes___ No___ Home Phone: _____ Other Phone: _____

Hours of Care Information

What hours would your child typically need care at Little Eagles Academy? _____ **to** _____

Medical/Special Needs Information

Child's Doctor _____ Office Phone _____
Address _____
Child's Dentist _____ Office Phone _____
Address _____
Hospital Preference _____
Insurance Carrier _____ **Policy #** _____

Please check any of the following health concerns or problems related to your child:

___ Behavior/Emotional Problems
___ Medically Fragile
___ Developmental Delays
___ Rashes
___ No Significant Health Concerns
___ Hyperactivity
___ Fears (what kind? _____)

List any allergies and the type of symptoms and type of response required for allergic reactions:

_____
_____

List any specialized health care services or chronic health conditions (i.e. – asthma, diabetes, seizure disorder):

_____
_____

List any medications your child currently takes:

_____
_____

For any child with health care needs such as allergies, asthma or other chronic conditions that require specialized health services, a completed medical action plan shall be attached to the application. Please notify staff upon completion of application if an action plan is needed and a copy will be provided to you.
To be completed by LEA staff: Is there a medical action plan attached: ___Yes ____No

Does your child have a disability or special need? Yes ___ No ___ Suspected ___

If Yes, what is diagnosis? _____
Does you child have an IEP or IFSP? Yes ___ No ___ Date of Plan: _____
Is your child receiving services related to disability? Yes ___ No ___
If yes, please list services:

_____

If No, has your child been referred for services related to the suspected disability?
Yes ___ No ___
If yes, who has child been referred to? _____

In the event of an emergency, I give my permission for the provider to secure needed emergency medical care in the event that neither the family physician nor I can be contacted immediately. I further understand that emergency medical care may be obtained from the closest available emergency room facilities, regardless of parent/guardian preference expressed to provider.

_____
(Signature of Parent/Guardian) **(Date)**