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)

Address _____ City _____ Zip Code _____

Date of Birth _____ Gender _____

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 Creative Academy? _____ to _____

Medical History & Information

Child's Doctor (please check one):

_____ Goldsboro Pediatrics – 2706 Medical Office Pl Goldsboro, NC 27530 (919-734-4736)
_____LaGrange Pediatrics - 114 E Railroad St, La Grange, NC 28551 (252-566-5999)
_____Mount Olive Pediatrics - 327 NC-55, Mt Olive, NC 28365 (919-658-9123)
_____SJAFB - 2803 Medical Campus Dr SJAFB, Goldsboro, NC 27531 (919-722-1802)
_____Other _____

Child's Dentist (please check one):

_____Goldsboro Pediatric Dentistry - 300 S Center St, Goldsboro, NC 27530 (919-947-0800)
_____Smith and Adams Dentistry - 2300 Wayne Memorial Dr, Goldsboro, NC 27534 (919-734-3564)
_____Hinnant Family Dentistry - 2603 N Hospital Rd, Goldsboro, NC 27534 (919-735-2226)
_____LaFevers Dental Team -101 Stevens Memorial Place, Goldsboro, NC 27534 (919-736-4830)
_____Other_____

Hospital Preference _____ **Insurance Carrier** _____

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

___ Behavior/Emotional Problems ___ Hyperactivity
___ Medically Fragile ___ Developmental Delays
___ Rashes ___ Fears (what kind? _____)

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

_____

Is your child under a doctor's a care? If so, please list reasons:_____

Has your child any previous hospitalizations or operations? If so, please list: _____

List any medications your child currently takes: _____

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

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 Creative Academy 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)**

HOW DID YOU HEAR ABOUT US?

Friend_____ Center Website_____ Yellow Pages_____ Search Engine_____
Other (Please specify)_____