



Date of Application: _____

School: _____

Child's Information

child's first name: _____

child's last name: _____

address: _____

City: _____ state: _____ zip code: _____

birth date: ____ / ____ / ____ age: _____

Parent Information

mother's name: _____

address (if different): _____

City: _____ state: _____ zip code: _____

phone # | home: ____ - ____ - ____ | work: ____ - ____ - ____

| cell: ____ - ____ - ____

mother's employer : _____

hours : _____

father's name: _____

address (if different): _____

City: _____ state: _____ zip code: _____

phone # | home: ____ - ____ - ____ | work: ____ - ____ - ____

| cell: ____ - ____ - ____

father's employer : _____

hours : _____

In an EMERGENCY call (other than parents):

- 1. _____ phone # | home: _____ - _____ - _____
relationship: _____
- 2. _____ phone # | home: _____ - _____ - _____
relationship: _____
- 3. _____ phone # | home: _____ - _____ - _____
relationship: _____

Allowed to pick up

- 1. _____ phone # | home: _____ - _____ - _____
relationship: _____
- 2. _____ phone # | home: _____ - _____ - _____
relationship: _____
- 3. _____ phone # | home: _____ - _____ - _____
relationship: _____

NOT Allowed to pick up my child (please be specific)

- 1. _____ phone # | home: _____ - _____ - _____
relationship: _____
- 2. _____ phone # | home: _____ - _____ - _____
relationship: _____
- 3. _____ phone # | home: _____ - _____ - _____
relationship: _____

parent signature: _____ date: _____

Child's History

Has your child previously attended a Child Care Center? YES _____ NO _____

Medical History

family Doctor & or clinic : _____

address: _____

City: _____ state: _____ zip code: _____

phone # _____ - _____ - _____

Dentist: _____ phone # _____ - _____ - _____

I give permission to _____
to make whatever emergency measures are deemed necessary for
the care and protection of my child, while under the supervision of
the program's Director and Staff.

In case of a medical emergency, I understand that my child will be
transported to

_____ by the local
emergency unit for treatment, at my expense, meaning guardians, if the
local emergency resource (Police, Rescue Squad) deems it necessary.

In event of an accidental ingestion, I understand that

_____ will contact the Poison Control Center. I give my permission for the staff
to administer Syrup of Ipecac to my child if directed to do so by the
Poison Control Center.

I hereby authorize _____
to act on my behalf in case of an emergency. I have read the following
information and have filled it out to the best of my knowledge. I will
adhere to all the Rules and Regulations set forth by this facility.

parent signature: _____ date: _____



Details of Medical History

child's name: _____ date: _____

parent or guardian: _____

Please list any illness or history your child may have concerning medical and/or mental illness. This is a confidential document and only serves to assist us in providing each child with the individual care they may need. The staff of Foundation R.O.C.K. is trained in confidentiality. Please feel free to notify the Director of the facility of any personal concerns you may have.

parent or guardian's signature: _____

date: _____



I understand in the event of a natural disaster,
Two circumstances may exist:

1— Our program will shut down for mandatory evacuation
of Vermilion and or Iberia parishes.

Parish, Parents/Guardians will be liable for payment
of shut down dates.

2— Program cancellation due to disaster results,
Parents/Guardians will be refunded, or deemed not
liable for remainder of monthly balance starting at
date of damage.



parent or guardian's signature: _____

date: _____