



## KIDZSPACE DAYCARE

106 Pecan Lane  
Fredericksburg, VA 22405  
703.677.2438

### Student Enrollment Information

Admission Date \_\_\_\_\_ Withdrawal Date \_\_\_\_\_

Please Fill out **all** information completely, including all addresses.

#### **Child Information**

Date of child's 1<sup>st</sup> day (approx.)

\_\_\_\_\_

Child's Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Middle Name \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Living Arrangement: ( ) Both Parents ( ) Mother ( ) Father ( ) Other \_\_\_\_\_

Home

Address \_\_\_\_\_

\_\_\_\_\_

Home Phone \_\_\_\_\_

\_\_\_\_\_

Legal Guardian(s): ( ) Both Parents ( ) Mother ( ) Father ( )

Other \_\_\_\_\_

If your child is under 5, are they ( ) Potty Trained ( ) In Pull-ups (if over 2) ( ) In Diapers (if under 2)

If your child is over 5 and attends school, please specify school name

\_\_\_\_\_

## **Parent Information**

### **Parent 1**

( ) Mother ( ) Father ( ) Other

\_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Home Address \_\_\_\_\_

\_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work \_\_\_\_\_

Address \_\_\_\_\_

E-Mail Address \_\_\_\_\_

### **Parent 2**

( ) Mother ( ) Father ( ) Other

\_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Employer \_\_\_\_\_

Work \_\_\_\_\_

Address\_\_\_\_\_

E-Mail Address\_\_\_\_\_

**Emergency Information** (Must have doctor's name and phone number)

**Family Doctor**

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Office Hours \_\_\_\_\_

**Family Dentist**

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Office Hours \_\_\_\_\_

**Emergency Contacts (list at least 3 )**

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

3. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

4. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

**Authorized Pick-Ups** (must have complete addresses)

**Only the people listed will be allowed to pick up your child. Including parents.**

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

3. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

4. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Child's Medical Information**

Does your child have any physical limitations, mental health disorders, mental retardation, developmental disabilities, or behavior disorders which could limit or challenge the child's participation in the center's programs and activities? ( ) Yes ( ) No

If yes, specify: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there any special instructions in caring for your child? ( ) Yes ( ) No

If yes, specify: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies**

Does your child have allergies (insect, seasonal, medications, foods, etc.)?

( ) Yes ( ) No If yes, specify:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any foods that your child may be allergic or sensitive to as our center nutritionist uses this information. Please note that a doctor's note and/or allergy form will be required. Parents may be required to bring in meals from home depending on the allergy and severity.

Child's Name \_\_\_\_\_ Food List:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergic reaction that occurs when ingested: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does your child have an epipen? ( ) Yes ( ) No

If there are any special instructions concerning your child's allergies or allergic reactions, please specify \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Your child's health, welfare, and safety are the primary concerns of the staff members at KIDZSPACE DAYCARE. The information requested is very important to ensure that your child receives the necessary care required for them.

### **Vehicle Emergency Medical Information**

We realize that the information requested below has been given on previous pages, however it is important that you complete this form in its entirety. This form is to be removed and given to paramedics in the unlikely event of a medical emergency.

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
\_\_\_\_\_

Mother's Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
\_\_\_\_\_

In case of an emergency and parents cannot be reached, contact:

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_  
\_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
\_\_\_\_\_

Child's Doctor Name \_\_\_\_\_ Phone \_\_\_\_\_

Child's Allergies \_\_\_\_\_  
\_\_\_\_\_

Current Prescribed Medication \_\_\_\_\_  
\_\_\_\_\_

Child's Special Needs and  
Conditions \_\_\_\_\_

In the event of an emergency involving my child, and if KIDZSPACE DAYCARE is unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I (we) shall assume responsibility for payment for services.

I (we) agree to keep the facility informed of any incidents requiring professional medical attention involving my child.

Child's Name \_\_\_\_\_

Parent or Legal Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

### **Parental Agreements with KidZSpace Daycare**

Enrollment Information: My child is normally in attendance at the facility between the hours of \_\_\_\_\_ am/pm to \_\_\_\_\_ am/pm on the following days: (Circle all that apply)

Monday      Tuesday      Wednesday      Thursday      Friday

My child will normally receive the following meals while in care: (Circle all that apply)

Breakfast      Lunch      PM Snack

1. **KidZ Space** agrees to provide child care for \_\_\_\_\_ (child's name)  
on Monday through Friday. My child will be allowed to participate in the following meal plans: Breakfast ( 730 until 8:30 am), Lunch (served starting at 11:30am ), and Afternoon snack (3:00 pm).
2. Before any medication is dispensed to my child, I will provide written authorization, which includes date, name of child, name of medication, prescription number, if any, dosage, and date and time medication is to be given. Medication will be in the original container with my child's name marked on it. Along with a doctor's note for their file.
3. My child will not be allowed to enter or leave the facility without being escorted by myself, the parent, person authorized by the parent, or facility personnel.
4. I acknowledge that it is my responsibility to keep my child's records current to reflect any significant changes as they occur, (telephone numbers, work location, emergency contacts, child physician, child's health status, infant feeding plans, immunization records, etc.)
5. The facility agrees to keep me informed of any incidents, including illnesses, any injury, adverse reaction to medications, etc. that involve my child.
6. The facility agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water related activities occurring in water that is more than two (2) feet deep.
7. I acknowledge that it is my responsibility to follow all policies & procedures. I acknowledge that **KidZSpace** has the right to terminate my child care contract at any time, for any reason, including but not limited to: the parent regularly breaks the rules, the parent is disruptive or difficult to deal with, the child is disruptive or difficult to manage (**KidZSpace** does not discriminate against the parent's or child's race, sex, religion, ethnic background, national origin or disability).

8. I have received a copy, read, and agree to abide by the policies and procedures for KidZ Space.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Parent or Legal Guardian)

Authorization to Dispense External Preparations

590-1-.20(1)

Parental Authorization: Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child's physician or parent. Such authorization will include, when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; dates to be given; the time of day to be dispensed; and signature of parent.

I give \_\_\_\_\_ Chanel Lacey \_\_\_\_\_ permission to apply one or more of the following topical ointments/preparations to my child in accordance with the directions on the label of the container.

\_\_\_\_\_ Baby Wipes

\_\_\_\_\_ Band-aids

\_\_\_\_\_ Neosporin or similar ointment

\_\_\_\_\_ Bactine or similar first aid spray

\_\_\_\_\_ Sunscreen

\_\_\_\_\_ Insect Repellent

\_\_\_\_\_ Non-Prescription ointment (such as A & D, Desitin, Vaseline)

\_\_\_\_\_ Baby Powder

Other (please specify) \_\_\_\_\_

Child's Name \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

