2025 REGISTRATION APPLICATION

Date Enrolled _____

Custody Alert _____

Student Information/Informacion del Estudiante

First Name/ Primer Nombre	Middle/Segundo Nombre		Last/Apellidos

Complete Address/Direccion Completa:

City/Ciudad | **State**/Estado | **Zip Code**/ Codigo Postal

Age/Edad: _____

Child must be 4 by August 31, 20___/El(la) nino(a) debe tener 4 anos para el 31 de agosto del

Country of Birth: _____

DOB/Fecha de Nacimiento:

_____/_____/_____

Month Day Year

Mes Dia Ano

Gender/Genero:

Male ☐

Female ☐

Is your child Hispanic or Latin? ☐ **Yes**/Si ☐ **No**/No

Race/Raza: (check all that apply/marque todas las que apliquen)

☐ **African American/** Afro Americano(a) ☐**White**/European American/Blanco(a)

☐**American Indian or Aslaska Native**/ Indio(a) Americano(a) Nativo(a) de Alaska

☐**Native Hawaiian or Other Pacific Islander**: Nativo(a) Hawaiano(a) o de las del Pacifico

☐ **Asian**/ Asiatico(a)

Is your child a U.S. Citizen? ☐ **Yes**/Si ☐ **No**/No

FAMILY CONTACT INFORMATION/Informacion de Contactoo de la Familia

Mother/Step-mother's/Guardian's Name: _____

Lives with child: ☐ **Yes**/Si ☐ **No**/No

Primary Phone Number: _____

Alternate Phone Number: _____

Email Address: _____

Father/Step-father's/Guardian's Name: _____

Lives with child: ☐ **Yes**/Si ☐ **No**/No

Primary Phone Number: _____

Alternate Phone Number: _____

Email Address: _____

Is there any legal paperwork pertaining to your child that we should be aware of? (This can include custody agreements, IEP paperwork, etc) Yes ☐ No☐

If yes, Please explain.

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CONTACTS

Child will be released only to the parents/guardians listed above. The child can also be released to the following individuals, as authorized by the person who signs the application. In the event of an emergency, if the parents cannot be reached, the facility has the permission to contact the following individuals.

Name	Relationship	Address	Phone Number
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HEALTHCARE NEEDS

For any child with health care needs such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child's parent or health care professional. Is there a medical action plan attached? Yes ☐ **No**☐

List any allergies and the syptoms and type of response required for allergice reactions:

List any particular fears or unique behavior characteristics the child has:

List any types of prescription or over the counter medications taken for health care needs:

SPECIAL NEEDS

Does Your child have an Individualized Education Plan (IEP) through the Exceptional Children's Program?
☐ Yes ☐ No
Does your child receive : ☐ Speech Therapy ☐ Occupational or Physical Therapy
Does your child have a chronic health condition, or a significant health concern diagnosed by a doctor?
☐Yes ☐No

DIETARY ROUTINES

Are there any dietary food restrictions? ☐ Yes ☐ No If Yes, Please explain.

EMERGENCY MEDICAL CARE INFORMATION

Name of Health Professional _____ Office Phone: _____

Hospital preference _____ Phone: _____

I, as the parent/guardian, authorize Dee's house to obtain medical attention for my child in an emergency.

Parent/Legal Guardian Signature/Firma del Padre/Guardian _____ Date _____