



grace christian child development center

2605 Jefferson Davis Hwy. Sanford, NC 27332
Mailing: P.O. Box #1408 Sanford, NC 27331
Phone: 919-776-2576 FAX: 919-869-1462
Web: www.gracecdcsanford.com

BEFORE & AFTER SCHOOL CARE APPLICATION

(to be completed & placed on file prior to enrollment)

Office Use Only

Date Received: _____

Interview/Tour Completed: Yes No

Enrollment Status: Offered Declined

Application Complete: Yes No

Date of Application: _____

Date Available for Enrollment: _____

How did you hear about Grace Christian Child Development Center? _____

If Referred, by: (Name) _____ (Relationship) _____

PERSONAL INFORMATION

Name of Child: _____
(Last) (First) (Middle) (Nickname)

Child's Date of Birth (mm/dd/yyyy): ____ / ____ / ____ Child's Current Age: _____

Current Physical Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if different) _____

School Currently Attending: _____ Grade: _____ Teacher: _____

FAMILY & MEDICAL INSURANCE INFORMATION

Father/Guardian

Name: _____
(Last) (First) (Middle)

Current Physical Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: () _____ - _____ Mobile Phone: () _____ - _____

Mailing Address (if different) _____ Email Address: _____

Name of Employer: _____ Employer Phone: () _____ - _____ Ext. _____ Department: _____

Mother/Guardian

Name: _____
(Last) (First) (Middle)

Current Physical Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: () _____ - _____ Mobile Phone: () _____ - _____

Mailing Address (if different) _____ Email Address: _____

Name of Employer: _____ Employer Phone: () _____ - _____ Ext. _____ Department: _____

EMERGENCY CARE INFORMATION

Name of Child's Doctor: _____ Name of Practice: _____ Phone: () _____ - _____

Office Address: _____ City: _____ State: _____ Zip Code: _____

Name of Child's Dentist: _____ Name of Practice: _____ Phone: () _____ - _____

Office Address: _____ City: _____ State: _____ Zip Code: _____

Hospital Preference: _____ City: _____ Phone: () _____ - _____

Child's Medical Insurance Carrier: _____ Group # _____ Policy # _____

If neither father nor mother (guardian) can be immediately contacted, whom should we contact?

First Contact Name: _____
(Last) (First) (Title: i.e.: Mr., Mrs., Miss., Ms., Dr.)

Relationship to Child: _____ Home Phone: () _____ - _____ Business Phone: () _____ - _____

Second Contact Name: _____
(Last) (First) (Title: i.e.: Mr., Mrs., Miss., Ms., Dr.)

Relationship to Child: _____ Home Phone: () _____ - _____ Business Phone: () _____ - _____

Please provide information of persons to whom you authorize the release of the child to:
(Proper ID/verification will be required before release is granted.)

Name: _____ Relationship: _____ Home Phone: () _____ - _____

Work Phone: () _____ - _____ Mobile Phone: () _____ - _____

Name: _____ Relationship: _____ Home Phone: () _____ - _____

Work Phone: () _____ - _____ Mobile Phone: () _____ - _____

Name: _____ Relationship: _____ Home Phone: () _____ - _____

Work Phone: () _____ - _____ Mobile Phone: () _____ - _____

INFORMATION

Does the school your child currently attends have current immunization records on file? No _____ Yes _____

Does your child have any physical limitations? No _____ Yes _____ If yes, please explain: _____

Does your child have any chronic medical diagnosis? No _____ Yes _____
If yes, please explain: _____

Does the child have any known allergies? No _____ Yes _____ If yes, please explain: _____

Is your child currently taking any recurring doses of medication? No _____ Yes _____
If yes, please explain: _____

I agree, by signing below, that the operator may authorize the physician of his/her choice to provide emergency care in the event that neither I nor the family physician can be contacted immediately.

(Father/Guardian Signature)

(Date)

(Mother/Guardian Signature)

(Date)

I verify that all of the above information is true and correct. I understand that any falsification, intentional or otherwise, of any portion of this document may be grounds for my child's dismissal. I certify that I understand Grace Christian Child Development Center is a ministry of Grace Chapel Church. Furthermore, I have read and understand the statement of faith for Grace Chapel Church and by affixing my signature below, I certify that I am in agreement with and support the teaching of my child according to all content thereof and also understand that these are conditions of my child's enrollment in Grace Christian Child Development Center.

(Father/Guardian Signature)

(Date)

(Mother/Guardian Signature)

(Date)

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or any medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian. Provisions will be made for adequate and appropriate rest and outdoor play.

(Operator Signature)

(Date)



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Please carefully read the following, initial where indicated and sign below

I understand that as the parent/guardian of my minor child (name of child): _____, I am responsible for the granting of permission and consent to the following procedures as well as the actions and physical condition of my child while he/she is in the Summer Camp program. As such, I consent to the following:

I give my permission for my child to participate in all program activities.

Please list any possible exclusions: _____

Initials _____

Emergency Procedures

In case of emergency, I authorize the program staff to directly contact the persons named on the application for enrollment. I authorize the doctor/hospital listed to provide necessary medical treatment in case of emergency. If the parent, guardian, or authorized person cannot be contacted, the program's directors (or designated staff) are authorized to take necessary action for the health and welfare of my child. I agree that I am solely responsible for payment of all costs resulting from emergency medical treatment and/or ambulance services.

Initials _____

Transportation

I give permission for my child to participate in all field trips. I understand and consent that he/she, from time to time, will be walking or riding in an approved vehicle away from campus.

Initials _____

Sign In/Out Procedures and Responsibilities

I agree to abide by the sign in/out procedures as stated in the Parent Handbook.

Initials _____

Student Record Updates

I understand that I must keep my child's records up to date with current phone numbers to those authorized to pick up my child.

Initials _____

Movie Release

I authorize my child to watch "G" rated and "PG" rated movies in the Summer Camp program. All movies will be previously screened prior to viewing.

Initials _____

Sunscreen Release

I agree to authorize the staff to provide, apply and re-apply sunscreen to my child if it is deemed necessary for the safety and well-being of the child.

Initials _____

Parent or Guardian Signature

Date



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A Ministry of Grace Chapel Church
2605 Jefferson Davis Hwy.
Sanford, NC 27332

PARTICIPATION & RELEASE AGREEMENT

I _____, parent of _____, do hereby consent that my child may participate in ministry activities. I give permission to allow my child to ride in ministry vehicles. I do hereby release and forever discharge all sponsors, employees, volunteers, officers and board members of Grace Chapel Ministries (DBA Grace Christian Child Development Center) from any and all claims, demands, actions or cause of action, past, present, or future arising out of any damage or injury while participating in related activities. If medical care is needed, I understand that reasonable effort will be used to reach emergency contacts, but I give permission for emergency medical treatment to be given by certified personnel. I do understand that any financial obligations that are incurred for medical services will be my responsibility.

Allergies _____

Date of Last Tetanus Shot _____

Present Medications _____

Insurance: Policy Name _____

Plan # _____ ID# _____

Emergency Contact Name & Number

1. _____

2. _____

I, the undersigned, do hereby verify that the above information is correct.

*Parent's Signature or
Participant's Signature (if older than 19 years of age)*

Date