LOVELL WEEKDAY MINISTRY
APPLICATION FOR ADMISSION

PERSONAL INFORMATION

Child's Full Name _____ Known As _____

Birthdate _____ Sex _____ Home Phone _____

Home Address _____ Zip Code _____

Name of Mother _____

mployer _____ Business Phone _____

Employer's Address _____

Church Affiliation _____ Hobbies/Special Interest _____

Name of Father _____

Employer _____ Business Phone _____

Employer's Address _____

Church Affiliation _____ Hobbies/Special Interest _____

LIST NAMES OF PERSONS TO CONTACT WHEN PARENTS CANNOT BE REACHED

Name _____ Phone _____

Relationship to Child _____

Name _____ Phone _____

elationship to Child _____

Persons **NOT** authorized to visit or pick-up child _____

Name of Child's Physician _____

Address _____ Phone _____

Name of Hospital Preferred _____

Known Allergies _____

HEALTH HISTORY OF CHILD

Has child had any of the following? (please include age)

	YES	NO	AGE
Chicken Pox			
Mumps			
Hepatitis			
Diabetes			
Measles			
Other (Please list:)			

Does your child run high fevers easily? ☐ Yes ☐ No

If child has experienced any allergic reactions, how was it manifested? _____

_____

Has child ever been to dentist? ☐ Yes ☐ No; Age: _____

Has child ever had his/her vision checked? ☐ Yes ☐ No; Age: _____

Has child ever had his/her hearing checked? ☐ Yes ☐ No; Age: _____

Is child ☐ left handed; ☐ right handed?

Does child have any speech problems? ☐ Yes ☐ No

Time child eats breakfast _____ lunch _____ dinner _____

Please list any dietary restrictions: _____

Time child goes to bed at night? _____ awakes? _____

Does child sleep well? ☐ Yes ☐ No

Child's favorite indoor activities _____

Child's favorite outdoor activities _____

Does child have any special fears? ☐ Yes ☐ No; If yes, please explain: _____

Please list any other problems your child has that we should be aware of _____

What method(s) of discipline is/are used at home? _____

How would you describe your child's personality? _____

FAMILY AND SOCIAL HISTORY

(Answer only if you feel information will be helpful to us as we work with your child)

Marital Status of Parents _____

If separated or divorced, how long? _____

Are there custody/visiting arrangements? ☐Yes ☐No;

If yes, please explain: _____

If child is adopted, age at adoption_____Does child know he/she is adopted? ☐ Yes ☐ No

Please list any other centers, pre-schools, etc. your child has attended? _____

SCHOOL INFORMATION

School your child attends _____

Child's Teacher at school _____ Grade _____

Does your child ride a bus? ☐ Yes ☐ No; If yes, Bus Number _____

Car Rider? ☐ Yes ☐ No; If yes, who is responsible for transportation? _____

Do you wish for your child to work on homework at the day care? ☐ Yes ☐ No

Child's homework is ☐ a lot ☐ a little ☐ none

List any homework you wish your child not to do at daycare: _____

Our children occasionally watch movies rated G & PG. Do you have restrictions in which you do not wish your child to see? Please list: _____

Does your child participate in any of the following activities?

☐ Dance ☐ Gymnastics ☐ Sports – what kind? _____

Does your child have neighborhood playmates? ☐Yes ☐No; If yes, what are there ages?

_____

When and with whom does your child watch TV? _____

How did you first become acquainted with LOVELL WEEKDAY MINISTRY?

PERMISSION SLIP

AUTHORIZATION TO TREAT A MINOR

I (we) the undersigned parent, parents or legal guardian of _____,

a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act or a Dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital holding a current license to operate a hospital from the State of South Carolina Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Signature of Parent/Guardian _____ Date _____

List any restrictions: _____

Address _____

Birthdate _____ Allergies _____

Last Tetanus Booster _____

Any special medications or pertinent information: _____

Mother's Home Telephone _____ Business Phone _____

Father's Home Telephone _____ Business Phone _____

Family Physician _____ Phone _____

Insurance Company _____ Policy # _____

RELEASE

In the event that my child becomes ill or sustains an injury while in the care of the *Lovell Weekday Ministry* I give my permission to those in charge whatever steps are necessary to stop any bleeding. If it is not possible to reach the doctor named below or to receive my instructions for his care, consent is given to any licensed physician and/or surgeon called upon, to whom my child is taken, for treatment by them, or to administer drugs or medications, and perform such surgical procedures as he shall think the emergency requires for the relief of pain and to preserve his life and health. I will be responsible for all expenses incurred by such an illness or injury.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Physician's Name Phone

_____

Physician's Address

_____

Emergency Hospital Other

Please check below any of the following that the child has had:

	Hay Fever		Polio		Valley Fever
	Asthma		Meningitis		Rheumatic Fever
	Eczema		Diabetes		Joint Pains
	Hives		High Blood Pressure		Epilepsy
	Jaundice		Bronchitis		Tuberculosis
	Undulant Fever		Phenomena		Muscular Disorder
	Anemia		Earache		Fainting