

**Enrollment Application**  
**Children's PLACE, Inc.**  
625 Richmond Street, Huntington, WV 25702  
304-525-8586

1. Name: \_\_\_\_\_ Nick Name \_\_\_\_\_ DOB/Due Date : \_\_\_\_\_ Enrollment Date: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address City State Zip Code

Phone #s (1) \_\_\_\_\_ (2) \_\_\_\_\_ Parent's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Phone \_\_\_\_\_ Employers Name \_\_\_\_\_

Employers Address: \_\_\_\_\_ Business Telephone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Phone \_\_\_\_\_ Employers Name \_\_\_\_\_

Employers Address: \_\_\_\_\_ Business Telephone: \_\_\_\_\_

Special Visitation/Custody  
Considerations: \_\_\_\_\_

Who will typically pick up your child? \_\_\_\_\_

**Childs Medical Information/History**

2. Name of Family Doctor: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Name of Family Dentist \_\_\_\_\_ Telephone #: \_\_\_\_\_

Health Insurance Provider: \_\_\_\_\_ Policy # \_\_\_\_\_ Phone # \_\_\_\_\_

Does your child have any known allergy's, special medications, or other special needs? \_\_\_\_\_

List below any medications your child is receiving, how often, and prescribed by whom:

Medicine \_\_\_\_\_ Frequency \_\_\_\_\_ Physician's Name \_\_\_\_\_

3. Other Children in Family:

<u>Name</u>	<u>Birth Date</u>	<u>Sex</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Background information:**

4. Does your child have experience being cared for outside of the home?

In a group setting? \_\_\_\_\_

By a person other than parents? \_\_\_\_\_

**Has your child had any severely upsetting experiences such as divorce of parents, death in the family, frequent or recent moves, etc.?** \_\_\_\_\_

**Please list any information about your child which will be helpful in the experience adjusting to a new environment such as eating, sleeping, play, fears, habits, likes, dislikes, etc.** \_\_\_\_\_

**Remarks or Special Concerns:** \_\_\_\_\_

**I hereby agree to cooperate with the facilities regulations. In case of an emergency medical care is necessary, I hereby give my permission for my child to receive care by the attending physician.**

**Signed:**

\_\_\_\_\_  
**(parent or legal guardian)**

\_\_\_\_\_  
**(Date)**

**NOTE: A \$25.00 applications fee needs to be included with your application. Upon receipt of this enrollment fee, your child will be placed on the enrollment list.**