APPLICATION

HEALTH HISTORY OF CHILD
CHRISTIAN LIFE FELLOWSHIP DAYCARE

CHILD'S NAME_____DOB _____AGE _____ GENDER _____

ALLERGIES OF ANY KIND _____

IF ALLERGIC, HOW DOES IT MANIFEST?_____ _____

WHAT IS THE ALLERGY CAUSED BY? _____

PAST ILLNESSES OF ANY KIND _____

IF SO, LIST AGE AND DESCRIPTION _____

DOES YOUR CHILD HAVE FREQUENT COLDS? _____

BRIEFLY DESCRIBE ANY ILLNESSES LIKE EAR ACHES, VOMITS EASILY, STOMACH ACHES, SORE THROAT OR ANY OTHERS _____
_____

DOES CHILD RUN A HIGH FEVER EASILY? _____

HAS YOUR CHILD HAD ANY SERIOUS ACCIDENTS? _____

BRIEFLY DESCRIBE _____

ANY SURGERIES IN THE PAST OR PLANNING TO HAVE ANY? _____

BRIEFLY DESCRIBE _____

HAS YOUR CHILD BEEN TO A DENTIST? _____

HAS YOUR CHILD HAD A VISION TEST? _____

HAS YOUR CHILD HAD A HEARING TEST? _____

ANY CORRECTIVE SHOES IN THE PAST OR PRESENT? _____

PLEASE GIVE AN OVERALL EVALUATION OF YOUR CHILD'S HEALTH:

_____
_____

NAME OF CHILD'S DOCTOR _____PHONE #_____
NAME OF CHILD'S DENTIST_____PHONE #_____

RELEASE AGREEMENT

CHRISTIAN LIFE FELLOWSHIP DAYCARE

CHILD'S NAME _____

DOB _____ AGE _____

PARENT OR GUARDIAN _____

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ EMPLOYER NAME _____

HOME ADDRESS

_____

_____

EMAIL ADDRESS _____

YOU HAVE MY/OUR PERMISSION TO RELEASE MY/OUR CHILD TO THE FOLLOWING INDIVIDUALS:

NAME _____ PHONE #'(S) _____
RELATIVE/OTHER _____

NAME _____ PHONE #'(S) _____
RELATIVE/OTHER _____

NAME _____ PHONE #'(S) _____
RELATIVE/OTHER _____

NAME _____ PHONE #'(S) _____
RELATIVE/OTHER _____

IN CASE OF AN EMERGENCY…

CHRISTIAN LIFE FELLOWSHIP DAYCARE WILL CONTACT THE ABOVE PERSON IN THE ORDER OF LISTING, IF THE PARENT OR GUARDIAN IS NOT AVAILABLE.

I AUTHORIZE CHRISTIAN LIFE FELLOWSHIP DAYCARE TO SECURE MEDICAL TREATMENT FOR MY CHILD IF I CANNOT BE REACHED.

PARENT/GUARDIAN SIGNATURE _____
DATE _____

Christian Life Academy
Tuition Payment Preference Form/Agreement
DAYCARE

Child's Names:

I. Personal Info (Person responsible for paying tuition)

Name _____ Phone _____

Last First

Address _____ S.S.# _____

City _____ St _____ Zip _____

DL# _____

II. Payment Options (Choose One)

B. Credit Card Payments Only

1.0 Credit Card Information

Type: ☐ VISA ☐ MasterCard

Credit Card Number (DO NOT use Debit/ATM Card)

Expiration Date Month Year

2.0 Payment Frequency and Schedule

Month of First Payment Month Year

Note: All credit card payments are processed on Friday's of each week

Number of Payments Desired per month

3.0 Payment Terms - Office Use Only

Weekly Balance Due $

Number of Payments $

Monthly fee $

X) _____

Signature of Person Responsible for Paying Tuition

Month Day Year

PLEASE ATTACH A COPY OF THE CHILD'S SHOT RECORDS TO THIS SHEET. A CHILD CANNOT BE ACCEPTED WITHOUT CURRENT IMMUNIZATIONS. WHENEVER THE CHILD IS GIVEN A NEW SHOT, OR SERIES OF SHOTS, A COPY MUST BE GIVEN TO CHRISTIAN LIFE FELLOWSHIP DAYCARE. THIS IS TO MAINTAIN A SAFE ENVIRONMENT FOR ALL CHILDREN.