



Admission Agreement & Health Assessment

Name of Child _____ Enrollment Date ____/____/____

Nickname _____ Birthdate ____/____/____ Sex F ___ M ___

Home Street Address _____ Phone # _____

City _____ State _____ Zip _____

Mother's/Guardian Name _____ Phone # _____

Home Address _____ E-mail address _____

S.S.# _____ D.L.# _____ Cell Phone # _____

Employer _____ Work Phone # _____

Father's/Guardian Name _____ Phone # _____

Home Address _____ E-mail address _____

S.S.# _____ D.L.# _____ Cell Phone # _____

Employer _____ Phone # _____

Out of Town emergency contact person: _____ Phone # _____

Address _____ If there are no out of town contacts check here

EMERGENCY CONTACTS (other than Parents) and Persons authorized to pick-up the Child...

Name	Relationship to Child	Address	Phone #

In case of emergency or serious illness, when parents can not be reached immediately, I hereby authorize Just 4 Kids Adventures to obtain emergency medical care and /or provide emergency medical transportation for my child

_____/_____/_____
 Signature of Parent or Guardian _____ Date _____

I hereby give Just 4 Kids Adventures permission to transport my child in there vehicle for the following (optional)

To and From School On Field Trips Other: _____

_____/_____/_____

I agree to pay \$ _____ per week on Monday of the week childcare is provided for Childcare services. In the event payment under this agreement is not made at the time and in the manner required there will be a \$5.00 per day late fee assigned. The undersigned agrees to pay all costs of collection, including attorney fees, court costs, including agency fee, which would be 45% of the balance assigned with or without suit.

Signature, Parent, or Guardian _____ Date _____

(See reverse side for the required Health Assessment form to be filled out)

The parent/guardian must review this form annually and changes as they occur must be noted.



Child Health Assessment

Please Write Clearly

Name of Child _____ Birth date ____ / ____ / ____

Check All That Apply:

Does your child have any known allergies or sensitivities to:

	No	Yes	if yes, please list
Medications	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foods	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

If so please provide a Doctors note of the Allergies.

Chronic Illnesses or Medical Conditions:

Does your child have any of the following?

	No	Yes		No	Yes
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Visual Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Developmental Delays	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Physical Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral Problems	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Problems	<input type="checkbox"/>	<input type="checkbox"/>
Other _____					

Please make a note of the severity of this conditions and how we can help with these conditions to better serve your child. _____

List any other health information or special instructions we need to be aware of to properly care for your child: _____

List any regular medications your child takes: _____
 Name of child's Medical Provider _____ Phone # _____
 Address _____

All information will be kept confidential.

I have disclosed all medical information about my child to you so that you may be able to care for him/her properly and if any thing new arises then I will disclose it to you as his/her provider.

Parent/Guardian signature _____ Date ____ / ____ / ____

Reviewed and or/update: ____ / ____ / ____ Parent/Guardian Signature _____
 Reviewed and or/update ____ / ____ / ____ Parent/Guardian Signature _____