

# Medina County Career Center

1101 West Liberty Street

Medina, Ohio 44256

330/725-8461

866/896-6222

## INFANT TODDLER APPLICATION FORM 2012-2013 School Year

### For Office Use Only

Date/time Received \_\_\_\_\_  
Received by \_\_\_\_\_  
Proof of Income \_\_\_\_\_ Birth Certificate \_\_\_\_\_  
Admittance date \_\_\_\_\_ Enrollment date \_\_\_\_\_  
Class \_\_\_\_\_ Category \_\_\_\_\_  
Medical Form on File YES NO  
Effective Date \_\_\_\_\_ Expires \_\_\_\_\_

### Program of Interest (Please check only one)

- Medical Assisting  
 GED  
 High School program \_\_\_\_\_

**Child:** Last First Middle

Name: \_\_\_\_\_ Sex: [ M / F ] Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Place of Birth: \_\_\_\_\_

Child's Social Security Number: \_\_\_\_\_ Home School District: \_\_\_\_\_

Does your child have any special needs and/or handicaps?  Yes  No If yes, please explain \_\_\_\_\_

List any known allergies/medical problems \_\_\_\_\_

**Parent Roster:** May we include you on our parent roster?  Yes  No

### **Mother/Guardian:** (Person child lives with)

Last First Middle

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Cell Phone #: (\_\_\_\_) \_\_\_\_\_

Company/Employer Name: \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_

Reference Source: How did you hear about our school? \_\_\_\_\_

### **Father/Guardian:**

Last First Middle

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

Address (if different from Parent 1): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Cell # \_\_\_\_\_

Company/Employer Name: \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_ Second Work Phone #: (\_\_\_\_) \_\_\_\_\_

**CODE WORD** \_\_\_\_\_



## Child's Name

### Medical Information:

Physician: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_  
Dentist: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_  
Preferred Hospital: \_\_\_\_\_  
Insurance Provider: \_\_\_\_\_ Policy #: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

### Emergency Transportation Authorization:

State Law requires that we have written authorization from a child's legal guardian to seek medical help in the event of a medical emergency. Signing the statement of this letter will provide us with that authorization.

Our policy, in the event of a medical emergency is to contact you first. If we can't contact you, we will try to contact any others you may designate. In the event that we are unable to contact you or designated representative(s), or if the medical emergency warrants immediate response, we will act, on your behalf and in the best interests of the child

Authorization Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Parent's Signature: X \_\_\_\_\_  
Special Instructions (if any): \_\_\_\_\_

**II. Refusal To Grant Permission: Parent's Signature: X \_\_\_\_\_:**  
What action should be taken? \_\_\_\_\_

### Immunization Dates:

DPT: \_\_\_\_\_  
Polio: \_\_\_\_\_ \* \_\_\_\_\_  
MMR: \_\_\_\_\_  
HIB: \_\_\_\_\_  
Other: \_\_\_\_\_ Please Specify: \_\_\_\_\_

### Emergency Contact/Authorized Pick-up People: MUST have two additional people other than the parents

The child will only be released to a designated individual unless prior arrangements are made. If, based on the opinion of the instructor, this individual appears to be impaired, the child will NOT be released.

Contact (1) Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Second Phone #: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_  
Emergency Contact:  Yes  No Authorized to Pick Up:  Yes  No

Contact (2) Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Second Phone #: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_  
Emergency Contact:  Yes  No Authorized to Pick Up:  Yes  No

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**Child's Name**

<b>Schedule:</b>	<u>Check Days</u>	<u>Time In</u>	<u>Time Out</u>
<input type="checkbox"/>	Monday	_____	Monday _____
<input type="checkbox"/>	Tuesday	_____	Tuesday _____
<input type="checkbox"/>	Wednesday	_____	Wednesday _____
<input type="checkbox"/>	Thursday	_____	Thursday _____
<input type="checkbox"/>	Friday	_____	Friday _____

**Rate to be charged:** \_\_\_\_\_

<b><u>Names of other Children in the Family:</u></b>	<b><u>Birth Date</u></b>
_____	_____
_____	_____
_____	_____
_____	_____

**Preschool Screening Authorization:**

I/We \_\_\_\_\_  
(Parent/Guardian – Please print name)

give the Medina County Career Center Public Preschool Program permission to administer appropriate screens. These will include but not be limited to assessing basic developmental skills, speech, language, hearing, and vision.

Agree to Preschool Screening:                       Yes                       No

**The information on this application form is complete and true to the best of my knowledge.**

**X** \_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**

**MEDIA RELEASE**

I allow for my child's picture to be taken for media purposes related to publicity and or daily/special events for the Medina County Career Center

Child's Name \_\_\_\_\_

Parent's Name \_\_\_\_\_

Date \_\_\_\_\_

I do not give permission for pictures to be taken of my child.

Child's Name \_\_\_\_\_

Parent's Name \_\_\_\_\_

Date \_\_\_\_\_

# CHILD'S MEDICAL STATEMENT

(FOR CHILDREN BIRTH TO 36 MONTHS)

CENTER Medina County Career Center

ADDRESS 1101 W. Liberty St.  
Medina, OH 44256  
330.725.8461 or 866.896.6222

This is to certify that I have examined \_\_\_\_\_ on \_\_\_\_\_  
CHILD'S NAME DATE

and have found that said child:

1. has had the immunizations required by Section 3313.671 of the Revised Code for admission to school, or has had the immunizations required by the state department of health for infants and toddlers, or is to be exempted from these requirements for medical reasons.

### Immunization Record – Please enter month/day/year of each immunization

DTP 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ \*5 \_\_\_\_\_

POLIO 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ \*4 \_\_\_\_\_

\* The 5<sup>th</sup> DTP and the 4<sup>th</sup> polio shots are normally administered prior to kindergarten

Measles, mumps, rubella – usually combined as MMR \_\_\_\_\_

If separate, measles \_\_\_\_\_ mumps \_\_\_\_\_ rubella \_\_\_\_\_

HIB \_\_\_\_\_

Hep B \_\_\_\_\_ Varicella \_\_\_\_\_

2. Based upon his medical history and physical condition at the time of this examination, is free from apparent communicable disease and is in suitable condition to receive child day care.

\_\_\_\_\_  
Physician's Name  
(please print or type)

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Parent's Name  
(please print or type)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Child's Birthdate

\_\_\_\_\_  
CITY

\_\_\_\_\_  
STATE

\_\_\_\_\_  
ZIP

\_\_\_\_\_  
Telephone Number