



ECOS INFANTILES LEARNING CENTER

Enrollment Application

Completion of this form is required for enrollment. The information provided helps us better understand your child's needs and ensures compliance with state childcare licensing regulations.

Enrollment Information									
Child's Information									
Child's first name		Child's middle name			Child's last name			Child's nickname	
Age	Gender	Child's primary language			Parent/guardian/sponsor primary language				
Child's home address				City		State		Zip	
Child's mailing address				City		State		Zip	
Family Information									
List family members & pets your child lives with – include first names, relation and ages of siblings									
Parent/guardian/sponsor			Relationship to child			Home phone		Cell phone	
Home address				City		State		Zip	
Home email			Work email				Work phone		
Employer		Employer address			City		State		Zip
Employer		Employer address			City		State		Zip
Other parent/guardian/sponsor			Relationship to child			Home phone		Cell phone	
Home address				City		State		Zip	
Home email			Work email				Work phone		
Employer		Employer address			City		State		Zip
Employer		Employer address			City		State		Zip
Child Emergency Contact and Release Information (do not include parents/guardians/sponsors already listed above)									
- Emergency Contacts must be able to pick up the child within 1 hour of being notified. - Please notify the center if an Emergency Release Contact will pick up your child on a given day. - For the safety of your child, we request that all authorized pick up persons with whom staff is not familiar provide a photo ID at the time of pick up.									
Person #1			Relationship to child			Home phone		Cell phone	
Home address				City		State		Zip	
Home email			Work email				Work Phone		
Employer		Employer address			City		State		Zip
Employer		Employer address			City		State		Zip
Person #2			Relationship to child			Home phone		Cell phone	
Home address				City		State		Zip	
Home email			Work email				Work Phone		
Employer		Employer address			City		State		Zip
Employer		Employer address			City		State		Zip
Person #3			Relationship to child			Home phone		Cell phone	
Home address				City		State		Zip	
Home email			Work email				Work Phone		
Employer		Employer address			City		State		Zip
Employer		Employer address			City		State		Zip

- The persons designated in this section will be contacted by us if you cannot be reached in the event of a medical or other emergency. Our staff will only release your child to you or to those persons listed above.
- If you want a person who is not identified above to pick up your child, you must notify our staff in advance, in writing. Your child will not be released without prior authorization.
- In rare instances, we receive phone calls from parents when we must verify their identity. Therefore, we ask each family to create a Code Word in case we need to verify the person calling is you. Code Word: _____

Parent initial _____ Date _____ Staff initial _____ Date _____



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Medical Information

Child's name	Birth date	Height	Weight	Hair color	Eye color
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Distinguishing marks

Child's Medical & Developmental History

- Does your child have any special medical conditions? ☐ No ☐ Yes Explain _____
- Does your child have any chronic illnesses? ☐ No ☐ Yes Explain _____
- Does your child have diabetes? ☐ No ☐ Yes *If yes, please attach care instructions from your physician.*
- Does your child have asthma? ☐ No ☐ Yes *If yes, please attach care instructions from your physician.*
- Will rescue medications be held at the center? ☐ No ☐ Yes *If yes, please fill out forms required by our medication policy..*
- Does your child have any special dietary needs? ☐ No ☐ Yes Explain _____
- Is your child able to fully participate in all activities? ☐ Yes ☐ No Explain _____
- Does your child have any physical restrictions? ☐ No ☐ Yes Explain _____
- Does your child function at the level of other children in his/her age group? ☐ Yes ☐ No Explain _____
- Is your child able to walk? ☐ Yes ☐ No
- Can your child communicate his/her needs? ☐ Yes ☐ No
- Does your child need assistance at mealtime? ☐ No ☐ Yes Explain _____
- Does your child nap or rest during the day? ☐ No ☐ Yes
- Is your child toilet trained? ☐ No ☐ Yes
- Does your child use any special equipment, such as breathing machine, wheelchair, hearing aid, braces, glasses etc.? ☐ No ☐ Yes Explain _____
- Does your child require any accommodations or modifications to fully and equally enjoy and participate in a group care setting? ☐ No ☐ Yes Explain _____

Child's Medical Care Providers

Primary physician's name	Primary physician's practice name	Phone
Preferred hospital/clinic for emergency care	City	State
Dentist's name	Dentist's practice name	Phone

To the best of my knowledge the information contained above is accurate.

Parent initial _____ Date _____

Staff initial _____ Date _____



Date of Enrollment _____

Additional Medical Policies

Initial

1. Prior to enrollment, I must provide the center with updated medical and immunization information for my child. This information is to be kept current and updated in accordance with state childcare regulations.
2. I agree to provide information to the child care center about my child's conditions, illnesses, allergies or other needs.
3. If my child becomes ill with a *reportable* contagious disease, I understand that he/she will not be able to return until I bring in a physician's note stating that he/she is no longer contagious.
4. If my child becomes ill during his/her time at the childcare center, the staff will contact me to pick up my child. I will arrange for pick up as soon as possible and no later than 2 hours after being contacted. If I cannot be reached, the staff will contact those listed in the *Child Emergency Contact and Release*.

☐ Vision problems	☐ Nosebleeds	☐ Seizures
☐ Hearing problems	☐ Skin rashes	☐ Mouth sores
☐ Constipation	☐ Sore throats	☐ Fainting
☐ Diarrhea	☐ Ear infections	☐ Persistent cough
☐ Asthma/breathing problems	☐ Urinary tract infections	☐ Other

Please attach care instructions from your physician for any of these illnesses.

Medication Allergies		Reaction		Food Allergies		Reaction

[illegible]

				threatening?		

Please attach care instructions from your physician for any life-threatening allergies.

Emergency Medical Authorization & Consent

Initial

In case of a medical emergency, the staff will attempt to contact me. If I'm not available, those listed in the *Child Emergency Contact and Release* will be called.

In case of a medical emergency, I agree that my child may receive first aid and/or CPR.

In case of a medical emergency, I permit the transportation of my child to a local hospital or other urgent care facility, if necessary, by paramedics or other emergency personnel.

In case of a medical emergency, I will be responsible for the emergency medical expenses.

In case of an accidental ingestion of a poisonous substance, I consent to my child being treated as directed by the Poison Control Center.

Sunscreen and Diaper Cream

Initial

I give my permission to this center to apply ☐ **sunscreen** and ☐ **diaper cream** to my child. *Please check which products you will permit.*

I understand that I must supply my own sunscreen and/or diaper cream with a valid expiration date, and it will be labeled with my child's name. (Prescription diaper creams are covered by our Medication Policy.)

Staff initial Date



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Child's Name _____
Date of Birth _____
Date of Enrollment _____

Screening Information / Información sobre las pruebas de detección

Miscellaneous Screenings and Tests / Miscelánea de exámenes y pruebas:

Screenings are quick checks that help identify any potential concerns with a child's development, health, or well-being. These may include vision, hearing, dental, or developmental screenings, and they help ensure children receive any support they may need.

Las pruebas de detección son controles rápidos que ayudan a identificar cualquier posible preocupación con el desarrollo, la salud o el bienestar de un niño. Estos pueden incluir exámenes de la vista, la audición, dentales o del desarrollo, y ayudan a garantizar que los niños reciban el apoyo que puedan necesitar.

Please check all screenings that your child has had and add the date of the most recent of each.

Por favor, revise todas las pruebas de detección que su hijo haya tenido y agregue la fecha de la más reciente de cada una.

☐ Vision Screening /
Examen de la vista

☐ Dental

☐ Well-child Exam / Examen de niño sano

☐ Hearing Screening / Pruebas
de detección de audición

☐ Developmental / Del desarrollo

☐ Other/Otro _____

☐ Speech Screening /
Detección del habla

☐ Educational / Educativo

☐ Other/Otro _____

As part of the State of New Mexico's FOCUS program, which focuses on quality child care, EILC administers developmental screenings such as the ASQ3 and ASQ SE to the children. These screenings help us meet your child's individual developmental needs in the classroom.

Como parte del programa FOCUS del estado de Nuevo México, que se enfoca en el cuidado infantil de calidad, EILC administra evaluaciones de desarrollo como ASQ3 y ASQ SE a los niños. Estas evaluaciones nos ayudan a satisfacer las necesidades individuales de desarrollo de su hijo en el aula.

☐ I give my permission for my child to be screened.

☐ Doy mi permiso para que mi hijo sea examinado.

Signature / Firma _____

Date / Fecha _____