



# Little Hedgepeth Academy

Rocky River Campus

2400 Rocky River Road  
Charlotte, NC 28213  
(704) 599-KIDS

*"We care when you can't be there."*

Application Date: \_\_\_\_\_

Enrollment Date: \_\_\_\_\_

## APPLICATION FOR ADMISSION

To Be Completed and Placed on File Prior to Enrollment

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Last First Middle Nickname

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

Street City State Zip Code

### INFORMATION ABOUT THE FAMILY

Mother's/Guardian's Name: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

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

Street City State Zip Code

Where Employed: \_\_\_\_\_ Business Phone #: \_\_\_\_\_

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

Father's Name: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

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

Street City State Zip Code

Where Employed: \_\_\_\_\_ Business Phone #: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

### INFORMATION ABOUT YOUR CHILD

Does your child have any known allergies: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain \_\_\_\_\_

Please give any information concerning your child that will be helpful in his/her experience in group settings (such as play, eating, sleeping habits, special fears, likes and/or dislikes, etc.): \_\_\_\_\_

### EMERGENCY CARE INFORMATION

Name of Child's Doctor: \_\_\_\_\_ Office Phone #: \_\_\_\_\_

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

Street City State Zip Code

Name of Child's Dentist: \_\_\_\_\_ Office Phone #: \_\_\_\_\_

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

Street City State Zip Code

Hospital Preference: \_\_\_\_\_ Phone #: \_\_\_\_\_

If neither mother nor father (or guardian) can be contacted, call (please indicate relationship):

Name/Relationship: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ Office Phone #: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ Office Phone #: \_\_\_\_\_

If you cannot call for your child, please give the names of persons to whom the child can be released: \_\_\_\_\_

I agree that the operator may authorize the physician of his/her choice to provide emergency care in the event that neither the family physician nor I can be contacted immediately.

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of an emergency.

In an emergency situation, a responsible adult will supervise other children in the facility. I will not administer any drug or any medication without specific instructions from the physician of the child's parent, guardian or full-time custodian. Provisions will be made for adequate and appropriate rest and outdoor play.

Signature of Operator: \_\_\_\_\_ Date: \_\_\_\_\_