WEXP

Child's Application

Before Care ___ After Care ___ Both ___ Drop In ____

Full Name of Child: _____ Date of Admission: _____

Child's DOB: ___/___/___ Name the child goes by: _____

Are the child's immunization records housed at WEMS?: Yes _____ No _____ If not, list the agency where they are housed: _____

Address: _____ City: _____ Zip Code: _____

Parents/Custodial Parents:

Mother's Name: _____ Home Phone: _____

Address: _____ City: _____ Zip Code: _____

Employer: _____

Work Address: _____

Work Hours: _____ Work Phone: _____ Cell Phone: _____

Father's Name: _____ Home Phone: _____

Address: _____ City: _____ Zip Code: _____

Employer: _____

Work Address: _____

Work Hours: _____ Work Phone: _____ Cell Phone: _____

Custodial Parent's Name: _____

Email address for parent communication: _____

Financial Responsible Party: If Parents are divorced, the custodial parent listed above is considered the RESPONSIBLE PARTY in paying all fees to WEXP. If you share financial responsibility it is up to the responsible party to pay on the account and seek reimbursement.

Please initial that you have read the financial responsibility policy. _____

Transportation Plan:

Please list any other adults to whom your child may be released or are authorized to provide transportation for your child.

_____

Emergency Contact Information:

1) Name of the person, other than the child care provider, authorized to act for parent in an emergency.

_____

Home address: _____

Place & Address of Employment: _____

Work Hours: _____ Work Phone: _____

Home Phone: _____ Cell Phone: _____

2) Name of the person, other than the child care provider, authorized to act for parent in an emergency.

_____

Home address: _____

Place & Address of Employment: _____

Work Hours: _____ Work Phone: _____

Home Phone: _____ Cell Phone: _____

3) Name of the person, other than the child care provider, authorized to act for parent in an emergency.

_____

Home address: _____

Place & Address of Employment: _____

Work Hours: _____ Work Phone: _____

Home Phone: _____ Cell Phone: _____

Please list any **Allergies** or **Medical Conditions** that should be considered.

_____

Physician Contact Information:

Physician's Name: _____ Phone: _____

Physician's Address: _____

WEXP Contact Information: wexp.wems@gmail.com (preferred method)

615-944-2937

Parent Declarations:

I received a summary of the licensing requirements.

I do hereby authorize emergency medical care for my child.

I visited the facility prior to enrolling my child.

I received a copy of the child care facility's policy statement or handbook and payment contract. I have signed their copy verifying by receipt my understanding and agreement of their contract.

Signature of Parent/Guardian: _____ Date: _____

Information on this form shall be updated annually or as needed to ensure the protection of the child.

Date of last update with the Parent's initials:
