



Thrivalaska Enrollment Application

Today's Date: _____ Child's Full Name: _____

Sex: Male or Female Date of Birth: _____ Nickname(s): _____

Guardian Name: _____ Guardian Name: _____

Relationship: _____ Relationship: _____

Social Security #: _____ Social Security #: _____

Driver's License #: _____ Driver's License #: _____

Mailing Address: _____ Mailing Address: _____

Physical Address: _____ Physical Address: _____

City & Zip Code: _____ City & Zip Code: _____

Home Phone #: _____ Home Phone #: _____

Occupation: _____ Occupation: _____

Employer: _____ Employer: _____

Work Phone #: _____ Work Phone #: _____

Fax: _____ Fax: _____

Cell phone/ Pager #: _____ Cell phone/ Pager #: _____

E-mail address: _____ E-mail address: _____

Please describe who the child lives with? _____

Other siblings enrolled in this PNL Program: _____

Other siblings enrolled in a different PNL program: _____

Pick Up Authority:

Who is *authorized* to pick up your child? _____

Who is *restricted* from picking up your child? Please attach custody or court orders if relevant.

Parent/Guardian Signature

Date

Health:

1. Are there any previous or current medical conditions we should be aware of? If yes, please explain. _____

2. Are there any health conditions such as seasonal allergies or eczema, that may be experienced by the child, but don't always occur? If yes, please explain. _____

3. Does your child have any allergies? Yes _____ No _____ Unknown at this time _____
If yes, please list them. _____
4. If your child does have an allergic reaction, what does it look like? _____

5. If your child does have an allergic reaction, what steps need to be taken?

6. Do you have any concerns about your child's hearing, vision, or speech? If so, what are they? _____
7. Is your child currently taking medication? What is it and what is it prescribed for?

8. Does your child need any special attention in any of the following areas? Please be specific as to what assistance your child needs:

	Yes	Please Describe
Activity Level		
Behavior Management		
Feeding or Special Diet		
Physical		
Resting/ Sleep		
Toileting		

2. What type of guidance do you find most successful with your child? _____

3. What language is spoken in your home? _____
4. What are your child's favorite activities? _____

5. Does your child have any fears we should be aware of? _____

6. Who are the other people important in your child's life, such as babysitter, grandparents, friends, etc. _____

7. What person or programs have cared for your child until now? _____

8. Describe your family culture such as: family traditions, celebrations and holidays, mealtimes, special foods, routines, religion, ethnic background, health practices, clothing, etc.

9. What special interests, resources or abilities can you share with us? _____

10. Is there anything else about your family you would like to share with us? _____

Plan of Care for a Child's Individual Needs:

ThrivAlaska recognizes that all children have individual needs. Some children may have a diagnosed special need and all children may have an individual need at a particular time in their life such as a broken bone, family moving, a new sibling, impending divorce, or an emotional need arising from the loss of a loved one. We strive to meet the individual needs of all children whether it is from a long term diagnosis or a short term special situation. Please fill out the following information to help us best meet individual needs. This form should be updated every 3 months when a diagnosed special need is specified and may be used whenever a new situation arises. Please use the backs of these pages if you don't have enough room for a particular answer.

This Plan of Care is a team effort between parents/guardians, the program director and the caregiver working directly with the child. The parent may fill out the form in advance but will need to meet with staff in order to implement the plan.

Child's Name: _____ **Age:** _____

Initial here if your child does not have an individual need requiring attention at this time: _____

1. What is your child's individual need: _____

2. Does your child have a medical diagnosis? _____ If yes, what is it? _____

3. If your child has a diagnosis, and has an IFSP or IEP, Child Care Licensing requires that we have a copy. Have you provided a copy to Thrivalaska? _____ If not, please explain. _____

4. Have other evaluations been completed that may assist us in caring for your child? Please attach or describe. _____

5. What additional services does the child receive and what specialists are working with your child? Please circle any and all that apply. Occupational, Physical, Speech or Play Therapy, Mental Health, Educational Therapy, Counseling, Other: _____

6. What, if any, of these services need to be accommodated at Thrivalaska, such as time and space for a physical therapist? _____

Do any of the plans from other professionals have pieces that need to be implemented by Thrivalaska? If so, what are they and how will they be implemented? _____

7. What priorities, needs and/or concerns are there for your family? _____

8. What is the child's present cognitive or overall functional level and skills: _____

8. What emergency or unusual circumstance might arise from this special situation?

9. If your child's individual need at this time involves behavior issues that put your child, other children, or the staff at risk, what is the agreed upon plan of action that will keep all safe? _____

9. Will your child need special accommodations from Thrivalaska to meet their needs? Such as a proper height chair, wheel chair accessibility, need to call mom when upset, elevation for a broken leg, etc. If so, please describe: _____

10. Are there any specific services needed from Thrivalaska to meet functional outcome objectives?

Coordinating this service is the responsibility of: _____

Paying for this service is the responsibility of: _____

11. Will your child need special routine care such during eating, resting, toileting, diapering? If so, please describe: _____

12. Is your child taking medication? What is it and what is it prescribed for? Are there possible side effects we should be aware of? _____

13. Are any special emergency and or medical procedures required:

14. Does the Thrivalaska staff need any special training to provide care to your child? If so, please describe what it is and who will provide it: _____

15. How much does your child understand about the situation? _____

16. Please choose A, B, or C.

A. This information must remain confidential between the 3 listed below. ___ Yes ___ No

B. This information may be shared on a "need to know" basis including staff, classroom teachers and substitutes. ___ Yes ___ No

The "need to know" basis is to be determined by the 3 signers below. Please list who is responsible for sharing the information and how it will be shared: _____

C. This information is not confidential and may be known to others, including other children and families. _____ Yes _____ No

New Enrollment: This plan of care for _____, has been discussed between parent(s)/guardian(s), Thrivalaska director, and the child's direct caregiver, and agreed upon for the child's admission in the program.

-OR- Current Enrollment Update: This plan of care for _____, has been discussed between parent(s)/guardian(s), Thrivalaska director, and the child's direct caregiver, in order to best need the child's specific current need.

Photograph/Video Release:

I give Thrivalaska permission to use my child's photograph for advertisement purposes, in newsletters, brochures, etc.

Parent/Guardian Signature

Date

Enews:

I am interested in receiving the Thrivalaska bi-monthly enewsletter. Please send it to the following email address:

Field Trip Permission:

My child has permission to go on any fieldtrips made in conjunction with the Thrivalaska School Age program.

Parent/Guardian Signature

Date

Sunscreen/Insect Repellent Permission:

I give Thrivalaska staff permission to apply insect repellent and sunscreen when necessary. I will not send bottles of sunscreen or insect repellent with my child or in their backpack.

Sunscreen Yes _____
No _____

Insect Repellent Yes _____
No _____

Child's Name

Date

Signature of Guardian