



# Thrivalaska School Age 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 Thrivalaska Program: \_\_\_\_\_

Other siblings enrolled in a different Thrivalaska 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               |     |                 |



**Approach/Withdrawal-** How does your child usually react the first time to new people, new foods, new toys and new activities?

Initial Approach      1                                      3                                      5                                      Initial Withdrawal

**Physical Sensitivity-** How aware is your child of slight noises, slight differences in temperature, differences in taste, and differences in clothing?

Not Sensitive      1                                      3                                      5                                      Very Sensitive

**Intensity of Reaction-** How strong or extreme are your child's reactions? Does your child laugh and cry energetically, or does he/she just smile and fuss mildly?

High Intensity      1                                      3                                      5                                      Mild Reaction

**Distractibility-** Is your child easily distracted, or does he/she ignore distractions? Will your child continue to work or play when other noises or children are present?

Very Distractible      1                                      3                                      5                                      Not Distractible

**Positive or Negative Mood-** How much of the time does your child show pleasant, joyful behavior compared with unpleasant crying and fussing behavior?

Positive Mood      1                                      3                                      5                                      Negative Mood

**Persistence-** How long does your child continue with one activity? Does your child usually continue if it is difficult?

Long Attention Span      1                                      3                                      5                                      Short Attention Span

Family:

It is our goal to partner with parents to provide care and education in a way that compliments each family we serve. Through family culture, children gain a sense of who they are, a feeling of belonging, what is important, what is right and wrong, how to care for themselves and others, and what to celebrate, eat and wear. Please share information about your family that will assist us in providing sensitive, responsive care for your child.

1. Please write a paragraph describing your child: \_\_\_\_\_

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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.  
\_\_\_\_\_  
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\_\_\_\_\_
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:

Thrialaska 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.

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

*If your child has an individual need please complete the following, otherwise skip to page 9.*

**Child’s Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

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 Thrialaska? \_\_\_\_\_ 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 Thrialaska, 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 Thrialaska? If so, what are they and how will they be implemented? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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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:

| School Year | IEP Date | IEP Expires | Parent Initial | Staff Initial |
|-------------|----------|-------------|----------------|---------------|
|             |          |             |                |               |
|             |          |             |                |               |
|             |          |             |                |               |
|             |          |             |                |               |
|             |          |             |                |               |

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 \_\_\_\_\_ Insect Repellent Yes \_\_\_\_\_  
No \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Child’s Name Date Signature of Guardian