Kristie Bell, Director

April Watkins, Associate Director

Mallory Sharp, Office Manager

865-689-3940

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Preschool Care	**Infant Care**	**Parent's Day Out**
Monday-Friday	Monday-Friday	Tuesday&Thursday
6:30am-6:00pm	6:30am-5:30pm	9:00am-2:00pm

Preschool Care is a part of the Weekday Children's Ministries of
Wallace Memorial Baptist Church
701 Merchant Dr., Knoxville, TN 37912
wallaceknox.com

WALLACE WEEKDAY MINISTRIES
PRESCHOOL CARE & PARENTS' DAY OUT
APPLICATION FORM

Office Use Only:

Date of Birth _____

Waiting List Date _____

Enrollment Date _____

Pre-Enrollment Fee $_____

Preschool ____ Infant ____ PDO ____

Child's Full Name _____ DOB _____ Gender M/F

Child's Address _____ City _____ Zip _____

Mother's Name _____ Father's Name _____

Address (H)_____ Address (H) _____

City _____ Zip _____ City _____ Zip _____

Phone _____Text? Y/N Phone _____Text? Y/N

Employer _____ Employer _____

Does child live with both parents? Yes/No If not, which parent does child live with? M/F

Church currently attending, if any _____

Brothers (Name & Age) _____

Sisters (Name & Age) _____

What are your child's favorite activities? _____

Does your child have any fears? _____

Is there any other information you would like to share with us about your child?

_____

_____

I have received a copy of the Summary of Licensing Requirements for Child Care Centers as set forth by DHS.

Parent Signature: _____

Child's Medical Information & Health History

Child's Doctor_____ Phone _____ Fax _____

Address _____ City _____ Zip _____

Hospital Preference _____

The answers to these questions will help us to know if your child has any medical problems. We need this information in case he/she should become ill and we would be unable to reach you right away. Please circle the right answer. We will go over this checklist with you when you have finished.

Pregnancy and Birth

1. Were there any problems with the pregnancy or your child's birth? Yes No
2. Was his/her weight under 5 ½ pounds? Yes No
3. Did the baby have any problems in the hospital? Yes No

Medical Issues

4. Has your child ever been in the hospital over night? Yes No
5. Is your child taking any medicine? Yes No

If so, please list _____

Please list any side effects which might occur and the appropriate action we are to take:

_____

_____

6. Any allergies or reactions to medicine, DPT, or other shots or insects? Yes No
7. Has your child had asthma or wheezing? Yes No
8. Does your child have speech or hearing problems? Yes No
9. Has your child typically had more than 2 ear infections in a year? Yes No
10. Has your child had tonsillitis? Yes No
11. Does your child have trouble with his/her eyes or seeing? Yes No
12. Has your child had a bladder or kidney infection? Yes No
13. Does he/she have burning when urinating? Yes No
14. Does he/she have seizures, fits, or shaking spells? Yes No
15. Have you been told your child has a heart murmur? Yes No
16. Is your child able to play as hard as other children? Yes No
17. Has your child ever had a bumpy, swollen reaction to the TB skin test? Yes No
18. Has your child ever been with anyone who has TB? Yes No
19. Has your child ever had worms? Yes No
20. Does your child scratch his/her genital area? Yes No
21. Is his/her bottom or genitals red or sore? Yes No
22. Is your child a hemophiliac? Yes No
23. Is your child on a heart monitor? Yes No

24. Does your child have tubes in his/her ears? Yes No

Older Girls

25. How old was your daughter when she had her first period? _____
26. Does she have any problems with her period? Yes No

General Development

27. Is your child in special education classes in school? Yes No
28. Does your child get along with other children? Yes No
29. Is he/she usually happy? Yes No
30. When did your child last see a doctor? _____
31. Does your child have any allergies to medicine, insects, food, etc.? Yes No

If yes, please list _____

_____

32. Does your child have asthma or wheezing? Yes No
33. Does your child have seizures? Yes No
34. Does your child have any special problems not indicated above? Yes No

If yes, please explain _____

_____

Persons, other than parent, who is authorized to act in case of an emergency:

Name _____ Employer _____

Address (H) _____ Address (W) _____

Phone (H) _____ Phone (W) _____

Relationship to child _____ Work Hours _____

Medical Wavier

On those occasions when I am unavailable, I _____ authorize
(Parent's Name)
the staff of Wallace Weekday Ministries (Wallace Memorial Baptist Church) to obtain emergency medical assistance for _____.
(Child's Name)

Parent/Guardian Signature: _____ **Date:**_____