

APPLICATION FOR CHILD CARE SERVICES

Child's Name:		Birthdate:
Address:		
City:	State:	Zip Code:
Legal Guardian #1:		Relationship:
Rank/Grade:	Social Security Number:	
Address:		
Home Phone:	Business Phone:	Business Hours:
Cell Phone:	Pager:	Email:
Legal Guardian #2:		Relationship:
Rank/Grade:	Social Security Number:	
Address:		
Home Phone:	Business Phone:	Business Hours:
Cell Phone:	Pager:	Email:
Days/Hours when care is needed:		
Transportation arrangement to and from program:		
Composition of family:		
Languages spoken in the home:		
Signature of Legal Guardian		Date

NOTE: Insert and use Department of Defense (DD) Form 2652, *Application for Defense Department Child Care Fees*, with this application.

PRIVACY ACT STATEMENT

Purpose: Data is collected to effectively manage and operate a day care facility. Information relating to religious preference or religious activity is collected and maintained only for cultural and social enrichment activities.

Authority: Authority for maintenance of the system: 5 U.S.C. 301, Agency powers, departmental regulations; 5 U.S.C. 302, Agency powers, delegation of authority; 10 U.S.C. 133, Organization and powers, Under Secretary of Defense for Acquisition and Technology; 10 U.S.C. 2809 and 2812, Military construction of child care facilities; 42 U.S.C. Chap. 127, Coordinated services for children, youth, and families; 40 U.S.C. 490B, Child care services for Federal employees, 42 U.S.C. Chap. 67, Child abuse program; Pub. L. 101-189, Title XV, Military Child Care Act of 1989; E.O. 9397, SSN; and DoD Instruction 6060.2, Child Development Programs.

Routine Uses: These records may be disclosed outside DoD to physicians, dentists, medical technicians, hospitals, or health care providers in the course of obtaining emergency medical attention; and to Federal, State, and local officials involved with the child care or health services, including child abuse. In addition, the data may be disclosed for any of the "Blanket Routine Uses" published by DLA. A list will be provided upon request.

DISCLOSURE IS VOLUNTARY. Providing the data is voluntary. However, failure to provide answers to all or part of questions may result in refusal of day care services. DLA PRIVACY ACT SYSTEM NOTICE S400.20 (Day Care Facility Registrant and Application Records) applies.

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Special needs of parents impacting child development services:

Special Needs of your child:

We need to know about any health concerns relating to your child in order to provide the very best services while your child is at Child Development Services. Has your child been diagnosed, have difficulty with or receive medication or treatment for any of the following:

CHECK PROGRAM CHILD IS CURRENTLY ENROLLED IN:

CDC SA YS N/A (On waiting list)

Please check all that apply:

- Allergies (i.e., Food, Insects, Drugs): _____
- | | | |
|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Attention Deficit Disorder (ADD) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Shunt |
| <input type="checkbox"/> Attention Deficit Hyperactivity Disorder (ADHD) | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Skin Disorders |
| <input type="checkbox"/> Auditory or Hearing Problems | <input type="checkbox"/> Emotional Disability/Disorder | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Behavior or Social Conduct Concerns | <input type="checkbox"/> Fetal Alcohol Syndrome | <input type="checkbox"/> Toileting Concerns/Difficulties |
| <input type="checkbox"/> Bi-Polar Disorder or Manic Depressive Syndrome | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Tourettes Syndrome |
| <input type="checkbox"/> Bleeding Disorder (such as hemophilia) | <input type="checkbox"/> Mental Retardation | |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Migraine Headaches | |
| <input type="checkbox"/> Bone, Joint or Muscle Concerns | <input type="checkbox"/> Personality Disorder | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Sickle Cell Anemia | |
| <input type="checkbox"/> Other: _____ | | |
- My child is enrolled in the Exceptional Family Member Program at _____ (Installation Name)
- My child has no health, medical or behavioral concerns at this time.