



Begin a lifetime of learning with
LARAMIE COUNTY COMMUNITY COLLEGE
Children's Discovery Center
ACADEMIC LAB



1400 East College Drive • Cheyenne, Wyoming 82007
 307.778.1303

APPLICATION FOR ADMISSION

Child's information	
Child's start date:	Today's date:
Child's name:	Nickname:
Address:	City/State/ZIP:
Date of birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Previous preschool/child care/Head Start: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, where:

Options	
<input type="checkbox"/> Full-time (Monday-Friday, 6:30 a.m.-5:30 p.m.)	
<input type="checkbox"/> Part-time	For part-time, please complete the following:
<input type="checkbox"/> Hourly	Monday Time in _____ Time out _____
<input type="checkbox"/> Half-day	Tuesday Time in _____ Time out _____
<input type="checkbox"/> Full-day	Wednesday Time in _____ Time out _____
	Thursday Time in _____ Time out _____
	Friday Time in _____ Time out _____
<input type="checkbox"/> After School Program: What school is your child attending _____	
<input type="checkbox"/> Summer School Age Program: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time (Full-days)	

Application Fee — \$25 per application (non-refundable)		
Date fee paid:	Amount:	Initials (staff use only):

Deposit	
A deposit equal to the first full month's tuition is required to be paid at the enrollment meeting. The deposit is refundable or applicable toward the final bill.	
Date deposit paid:	Initials (staff use only):
Method of payment:	

DFS Provider Numbers
<input type="checkbox"/> Full-time, full-day and half-day: #831
<input type="checkbox"/> Hourly: #26066

Parent is
<input type="checkbox"/> LCCC Student <input type="checkbox"/> LCCC Employee <input type="checkbox"/> Community Member

Mother's information	
Name:	Home phone:
Physical address: <input type="checkbox"/> Same as child	City/State/ZIP:
Mailing address:	City/State/ZIP:
Date of birth:	Social Security number:
Employer and/or school:	Occupation:
Work address:	Work phone:
Email:	Cell phone or pager:

Father's information	
Name:	Home phone:
Physical address: <input type="checkbox"/> Same as child	City/State/ZIP:
Mailing address:	City/State/ZIP:
Date of birth:	Social Security number:
Employer and/or school:	Occupation:
Work address:	Work phone:
Email:	Cell phone or pager:

Siblings	
Name(s):	Birthdate(s):

Others authorized to pick your child up from the center	
<p>Other than the above named parents/guardians, list any person(s) you approve to remove your child from the LCCC Children's Discovery Center without previous notice. Photo ID will be required. Anyone not on this list will not be permitted to pick your child up from the center. These people may also be contacted in the event of an emergency.</p>	
Name(s):	Phone Number(s):

Medical information	
Family doctor/pediatrician:	Phone:
Dentist:	Phone:
List any frequent illnesses (i.e., ear infections, strep throat, seizures) and/or hospitalizations:	
List any known allergies:	
List any communicable diseases (i.e., chicken pox, measles, mumps) your child has had:	
Is your child currently taking medications? Yes No Dose: Time(s):	
Are there any special medical concerns we should know about?	

Therapeutic services	
Check any therapeutic services your child receives in a developmental center or at school.	
<input type="checkbox"/> Occupational therapy	<input type="checkbox"/> Speech therapy
<input type="checkbox"/> Physical therapy	<input type="checkbox"/> Behavior therapy
<input type="checkbox"/> Psychological or counseling services	

Communications concerns (Check all that apply.)	
<input type="checkbox"/> Wears glasses	<input type="checkbox"/> Lip reads
<input type="checkbox"/> Wears hearing aids	
<input type="checkbox"/> Uses light board or other adaptive device(s)	
<input type="checkbox"/> Uses sign language or hand signals	
<input type="checkbox"/> Speaks another language in the home. Please specify:	

Your child's needs
Is there anything we should know about your child to help us meet his/her needs?

AUTHORIZATION OF MEDICAL TREATMENT

Please indicate the names and phone numbers of those who can be reached in the event of an emergency.	
Father:	Phone Number:
Mother:	Phone Number:
Another Authorized Person:	Phone Number:
Another Authorized Person:	Phone Number:
<p>I, _____, hereby give permission to LCCC Children's Discovery Center to obtain emergency medical, dental or surgical care from a health-care facility, physician or dentist for my child, whose full name is _____ and whose date of birth is _____, should the need arise. It is understood that a conscientious effort will be made to locate me before action will be taken. If this is not possible, treatment as deemed necessary by the physician or dentist may be taken. I further consent to transportation of the above named child to the nearest or most appropriate medical facility.</p>	

The above-named child is covered by the following medical insurance company:	
Company Name:	
Company Address:	Company Phone Number:
Name of Policy Holder:	Policy Number:
<p>I authorize the hospital and attending physicians to submit claims to the above-named company and hereby assign benefits directly to this company. I understand that I am financially responsible to the providers of services for charges not covered by insurance.</p>	
Signature of Parent/Guardian	Date

If a sudden illness or serious medical emergency should occur and I cannot be reached, my signature below authorizes the LCCC Children's Discovery Center staff to call my child's physician or dentist or to take my child to the nearest emergency medical facility.	
Signature of Parent/Guardian	Date

ACTIVITY PERMISSION FORM

Child's Name:	
<p>Consent is being given for the items initialed below: (Please initial in the space preceding each event your child is authorized to attend.)</p> <p><input type="checkbox"/> Walking trips around the LCCC campus</p> <p><input type="checkbox"/> Trips in the Children's Discovery Center bus</p> <p><input type="checkbox"/> Gym Day at the LCCC PE Building</p> <p>In the event of an emergency on campus, all children will be transported to an off-site location and parents will be contacted.</p> <p>Separate permission will be requested for off-campus field trips.</p> <p>Children will be restrained during vehicular transportation by the use of seatbelts. Parents must provide an approved child-safety restraint system (car seat) for children under 8 years and 80 pounds.</p>	
Signature of Parent/Guardian	Date

SUNSCREEN AND INSECT REPELLENT PERMISSION FORM

Child's Name:	
<p>I understand that applying sunscreen and insect repellent is part of the LCCC Children's Discovery Center's program. I give LCCC Children's Discovery Center permission to apply sunscreen and insect repellent when taking my child outside.</p>	
Signature of Parent/Guardian	Date
<p>My child is allergic to most sunscreens and insect repellents. I will supply my child's sunscreen and insect repellent.</p>	
Signature of Parent/Guardian	Date
<p>I do not wish for my child to use sunscreen or insect repellent while attending LCCC Children's Discovery Center.</p>	
Signature of Parent/Guardian	Date

Photographs of the children participating in our programs may be taken from time to time and may appear in newspapers, magazines, brochures and other LCCC publicity materials. These photos help to bring awareness to our program and aid us in making the program more effective. Names of children photographed will never be printed.

By signing below, I give LCCC staff permission to photograph my child.

I request that photographs of my child be used only in the classroom.

Parent/Guardian Signature	Date
Parent/Guardian Signature	Date

By signing below, I hereby acknowledge that the information provided on this Application for Admission is true to the best of my knowledge.

Parent/Guardian Signature	Date
Parent/Guardian Signature	Date