CABIN JOHN BROOKMONT CHILDREN'S PROGRAM

CABIN JOHN/BROOKMONT CHILDREN'S PROGRAM, INC.
4000 Virginia Place ~ Bethesda, MD 20816
(301) 320- 6780 ~ www.brookmontkids.org

APPLICATION FORM

To apply to the program, please send the completed form,
with a $25.00 (non-refundable) application fee to:
Cabin John/Brookmont Children's Program, Inc., 4000 Virginia Place, Bethesda, MD 20816
DEADLINE: January 17, 2020

CHILD'S NAME: _____

BIRTHDATE (month/day/year): _____

MOTHER'S INFORMATION:

NAME: _____

ADDRESS: _____

_____

HOME PHONE: _____

CELL PHONE: _____

EMPLOYER: _____

OCCUPATION: _____

WORK PHONE: _____

EMAIL: _____

FATHER'S INFORMATION:

NAME: _____

ADDRESS: _____

_____

HOME PHONE: _____

CELL PHONE: _____

EMPLOYER: _____

OCCUPATION: _____

WORK PHONE: _____

EMAIL: _____

OTHER CHILDREN IN HOME (age, relationship):
_____

_____

OTHER ADULTS LIVING IN THE HOME (relationship):
_____

_____

LANGUAGE OTHER THAN ENGLISH SPOKEN AT HOME:
_____

PARENTS' SPECIAL TRAINING OR INTERESTS (which you might share with the school):
_____

_____

FAMILY SITUATION (anything that might be useful to us in helping the child understand him/herself, his/her family, and his/her world):

_____

_____

_____

PARENT'S CONCERNS (fears, eating or sleeping problems, thumb sucking, behavior problems, sibling relationships, etc.):

_____

_____

_____

SPECIAL EXPERIENCES (trips, hobbies, games, favorite toys, playmates, tv shows, etc.):

_____

_____

_____

RIGHT/LEFT HAND PREFERENCE: _____

WORDS USED FOR TOILET: _____

_____

IS THERE ANYTHING YOU WOULD LIKE TO SHARE ABOUT YOUR CHILD'S BACKGROUND AND PERSONALITY (Emotional Behavior: calm, excitable, easily angered, anxious, crying, happy, cheerful, negative, cooperative; Social Behavior: shy, friendly, fearful, aggressive)?

_____

_____

_____

_____

_____

_____

_____

_____

EMERGENCY INFORMATION:

EMERGENCY CONTACTS (to be contacted if parents cannot be reached)

PRIMARY EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____

PHONE: _____ NEAR CHILD'S HOME? _____

ADDRESS: _____

SECONDARY EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____

PHONE: _____ NEAR CHILD'S HOME? _____

ADDRESS: _____

MEDICAL HISTORY

PEDIATRICIAN: _____

PHONE: _____

HOSPITAL PREFERENCE: _____

SERIOUS PHYSICAL ILLNESS OR OPERATIONS (date):

_____

CURRENT MEDICATIONS:

_____

ALLERGIES:

FOOD _____

INSECT _____

OTHER _____

ACTIVITY RESTRICTIONS:

_____

_____

_____