

CENTRALIA COLLEGE - CHILDREN'S LAB SCHOOL

For Office Use	*DSHS approved *Applying for DSHS *Self Paying *WorkFirst *Teen Student *CC Student *UW		
	START DATE:	Comments:	

Application (picked up on _____) (mailed on _____) (left at window on _____)
 Slot reserved through _____ (3 days after pick-up/window date or 6 days after mail date)

APPLICATION

Date of Application	Signature of Custodial Parent/Guardian Responsible for Billing Obligation. If you make a DSHS co-pay, also sign.
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Child(ren) live with (1st Custodial Parent/Guardian)	2nd Participating Custodial Parent/Guardian (if applicable)
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1st Child Participating in Program	Birthdate	Room
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2nd Child Participating in Program	Birthdate	Room
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3rd Child Participating in Program	Birthdate	Room
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3rd Child Participating in Program	Birthdate	Room
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Child Lives With (Circle all that apply.):
 Both Parents Mother Father Grandparents Step Mother Step Father Foster Parents Other

1st Custodial Parent/Guardian's Name	Physical Address	City	State	Zip
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Work Name OR Write 'None'	Mailing Address	City	State	Zip
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Work Name OR Write 'None'	Work Address	City	State	Zip
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Work Phone	Cell Phone	Home Phone	Message Phone
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2nd Custodial Parent/Guardian's Name	Physical Address	City	State	Zip
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Work Name OR Write 'None'	Mailing Address	City	State	Zip
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Work Name OR Write 'None'	Work Address	City	State	Zip
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Work Phone	Cell Phone	Home Phone	Message Phone
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CONFIDENTIALITY

To protect the rights of children, parents, and teachers, I understand that all activities and conversations related to the children, parents, and teachers at the Lab School are strictly confidential and are not to be shared with anyone. I will refrain from talking about other children or parents. If I have any concerns or problems I will see the lead teacher or program manager. I will assume full responsibility for maintaining a professional attitude while I am at the

Custodial Parent/Guardian Signature	Date
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PARENT APPROVAL OF FORMULA - Please fill out if your child is on formula.

Our Infant Care Center provides the following formulas: Enfamil with Iron, Prosobee with Iron, Similac with Iron.

1. Please approve one of the formulas listed by **circling one**: Enfamil Prosobee Similac
2. I approve the use of this formula for my infant (**circle one**): YES NO
3. Please list the formula that you currently use: _____

If the formula you use is a low-iron or no-iron infant formula, a doctor's prescription must be on file at our center. The prescription must state the name of the formula substituted.

Custodial Parent/Guardian Signature	Date
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