



CHILD'S ENROLLMENT RECORD

DIRECTOR'S USE ONLY

Date enrolled _____

Child's full legal name _____
First Middle Last

Sex _____ Birth Date _____

Child's preferred name/nickname _____

Address _____
Street Address (number, apartment #, street) City State Zip

Primary hours child will be in the children's center _____

Days of week child will be in the children's center _____

Who has legal custody _____ Relationship _____

Address _____
Street Address (number, apartment #, street) City State Zip Code

Home Phone () _____ Cell Phone () _____

Parent's name _____

Home Phone () _____ Cell Phone () _____

Home address _____ Zip _____
Street Address (number, apartment #, street) City State Zip Code

Place of employment _____

Address of employer _____
Street Address (number, apartment #, street) City State Zip Code

Telephone () _____

Parent's name _____

Home Phone () _____ Cell Phone () _____

Home address _____ Zip _____
Street Address (number, apartment #, street) City State Zip Code

Place of employment _____

Address of employer _____
Street Address (number, apartment #, street) City State Zip Code

Telephone () _____

The child will be released only to the person(s) authorized, or in the manner authorized, in writing, by the custodial parent(s) or legal guardian(s). The following person must be someone other than the custodial parent(s) or legal guardian(s) and is authorized to remove the child from the facility in case of illness, accident, or emergency, **if for some reason the custodial parent(s) or legal guardian(s) cannot be reached:**

Name _____

Home Phone () _____ Cell Phone () _____

Address _____
Street Address (number, apartment #, street) City State Zip Code

Name _____

Home Phone () _____ Cell Phone () _____

Address _____
Street Address (number, apartment #, street) City State Zip Code

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CHILD'S ENROLLMENT RECORD
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Child's physician/health resource _____

Telephone Number (_____) _____

Address _____
Street Address (number, apartment #, street) City State Zip Code

Hospital preference _____

Name of Dentist _____ Telephone (_____) _____

Address _____
Street Address (number, apartment #, street) City State Zip Code

MISCELLANEOUS INFORMATION

List all known allergies _____

List all identifying scars, birthmarks, skin discolorations _____

Special medical or dietary needs of child _____

List any areas of concern _____

My signature below verifies that:

I give permission to consult the child's physician/health resource listed above in case of emergency if parent/guardian cannot be reached.

I have received a copy of the "Know Your Child's Children's Center" and "Influenza Virus" brochures and a copy of the children's center discipline policy.

I was notified that the snacks/ meals served daily are:

Breakfast AM Snack Lunch PM Snack Dinner

I verify that the information on this enrollment form is complete and accurate.

Signature of Custodial Parent or Legal Guardian

Date