## **Application For Enrollment**

Full Name:					
Last	F	irst		Middle	nickname
Child's Physical Address:					<del></del>
Primary Hours of Care: Fro	m:		To		
Days of the Week in Care:	M T W	V TH	F		
Family Information:	Child Live Wi	ith:			
Mother's Name:		F	ather's l	Name :	
Address:					
Home Phone:			Home Ph	none:	
Cell phone:			Cell Pho	ne:	
Employer:			Employe	r:	
Work Phone:			Work Ph	ione:	
			E-mail:		
E-mail: Custody: Mother  Medical Information: I hereby grant permission	Father:for the staff of	Botl	h	Other:	-
E-mail: Custody: Mother  Medical Information: I hereby grant permission to obtain emergency medic Doctor:	Father: for the staff of cal care if warr	this faci	nlity to co Phon _ Phon	Other: ntact the follow e : e:	ring medical personn
E-mail: Custody: Mother  Medical Information: I hereby grant permission to obtain emergency medic Doctor: Doctor: Hospital Preference:	for the staff of cal care if warr medical or diesersons will also liness, accident reached	this facilianted.	lity to co Phoneds or ot	Other:  ntact the follow e:e: her areas of cor d are authorized f for some reaso	ring medical personn medical personn ncern:
E-mail: Custody: Mother  Medical Information: I hereby grant permission to obtain emergency medic Doctor: Doctor: Hospital Preference: Please List allergies, specia  Contacts: The following perform the center in case of items or legal guardian cannot be Name:	for the staff of cal care if warr medical or diagrams will also liness, accident reached Phone	this facilianted.  etary necessit or eme	lity to co Phoneds or ote	Other:  ntact the follow e: e: her areas of cor d are authorized f for some reaso Relation to t	ring medical personn  cern:  d to remove the child on , the custodial par
E-mail: Custody: Mother  Medical Information: I hereby grant permission to obtain emergency medic Doctor: Doctor: Hospital Preference: Please List allergies, specia  Contacts: The following perform the center in case of it or legal guardian cannot be	for the staff of cal care if warr medical or dia resons will also liness, accident reached Phone Phone	this facilianted.  etary necessition emerges	lity to co Phoneds or ote	Other:  ntact the follow e: e: her areas of cor d are authorized f for some reaso Relation to t Relation to t	ring medical personn medical personn ncern:



## **Application For Enrollment**

		Sex:		
Full Name:				
	ast		Middle	nickname
Child's Physical Address:				
Primary Hours of Care: F				
Days of the Week in Care	e: M T W	TH F		
Family Information:	Child Live With:			
Mother's Name:		Father's Name:		
Address:		Address:		
Home Phone:		Home Phone:		
Cell phone:		Cell Phone:		
Employer:		Employer:		
Work Phone:		Work Phone:		
E-mail:		E-mail:		<del></del>
Custody: Mother	Father:	Both	Other:	
I hereby grant permission		s facility to contact th	ne following medi	cal personnel to obtain
emergency medical care Doctor:	if warranted.	Phone :		
emergency medical care Doctor: Doctor:	if warranted.	Phone : Phone:		
emergency medical care Doctor: Doctor: Hospital Preference:	if warranted.	Phone : Phone:		
emergency medical care Doctor: Doctor:	if warranted.	Phone : Phone:		
emergency medical care Doctor:  Doctor: Hospital Preference: Please List allergies, spec	if warranted.	Phone : Phone: ry needs or other are	as of concern:	
emergency medical care Doctor: Doctor: Hospital Preference: Please List allergies, spec	cial medical or dietal	Phone : Phone: ry needs or other are contacted and are a	as of concern: uthorized to remo	ve the child from the cent
emergency medical care Doctor: Doctor: Hospital Preference: Please List allergies, spec	cial medical or dietal	Phone : Phone: ry needs or other are contacted and are a	as of concern: uthorized to remo	ve the child from the cent
emergency medical care Doctor: Doctor: Hospital Preference: Please List allergies, specentials Contacts: The following case of illness, accident or	cial medical or dieta persons will also be or emergency, if for	Phone : Phone: ry needs or other are contacted and are as	as of concern: uthorized to remo	ve the child from the cent
emergency medical care Doctor: Doctor: Hospital Preference: Please List allergies, spec  Contacts: The following case of illness, accident of reached Name:	cial medical or dietal persons will also be or emergency, if for	Phone : ry needs or other are contacted and are as some reason , the cu Phone :	as of concern:  uthorized to remo stodial parent or I	ve the child from the centegal guardian cannot be
emergency medical care Doctor:  Doctor: Hospital Preference: Please List allergies, spec	cial medical or dietal persons will also be or emergency, if for	Phone : ry needs or other are contacted and are assome reason , the cu Phone : Phone :	as of concern:  uthorized to remo stodial parent or I  Relati Relati	ve the child from the cent

Parent/Legal Guardian Signature: