Enrollment Checklist

Below are the items needed for to enroll.

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday: \_\_\_/\_\_\_\_\_/\_\_\_\_\_

Enrollment Date: \_\_\_/\_\_\_/\_\_\_\_ Date of Start:\_\_\_\_/\_\_\_\_/\_\_\_\_

Front Office Items:

\_\_\_ Enrollment Application \_\_\_ Birth Certificate

\_\_\_Custodial Forms (if applicable) \_\_\_ Special Needs Documents (if applicable)

\_\_\_ Physical Form/Shot Record \_\_\_ Communicable disease

\_\_\_ IEP (if applicable) \_\_\_ Allergy Care Plan (if applicable)

\_\_\_ Registration Fee ($75 per child, $95 family)

Classroom Items: (infants/toddler see separate sheet)

\_\_\_ Nap Blanket \_\_\_ Spare Clothes (extra if potty training)

\_\_\_ Naptime box – 3’s classroom only (shoe box filled with quiet activities to be used if your child doesn’t sleep)

\_\_\_ Short bio on child/children

Office Use Only- Identity Verification

Place of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Certificate Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Issued:\_\_\_\_\_\_\_\_\_

Other Form Of Proof:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Director/Administrator’s Signature Date



81 & 85 Cleremont Drive

Fredericksburg VA, 22405

Phone: (540) 373-7791 Fax: (540) 373-6541

Child’s Last Name: Child’s First Name: Nickname:

Date of Birth: Sex: M F SSN:

Street Address: Home Phone:

City: State: Zip Code:

Special Accommodations Needed?

If child attends this center and another school/program, give name of school/program and grade.

Weekly Attendance (for scheduling purposes)

Full Time

Approximate Drop off Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Approximate Pick Up Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Part Time (care is based on set days each week and availability)

Part Time: Mon. Tue. Wed. Thurs. Fri. Approximate Drop off Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Approximate Pick Up Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents/Guardians

Mother’s/Guardian’s Name: SSN:

Street Address: Home Phone:

City: State: Zip: Cell Phone:

Employer’s Address: Work Phone:

City: State: Zip:

Email: Birthday:

Father’s/Guardian’s Name: SSN:

Street Address: Home Phone:

City: State: Zip: Cell Phone:

Employer’s Address: Work Phone:

City: State: Zip:

Email: Birthday:

**Emergency Information**

Allergies, Intolerances, Medications: Actions to take:

Child’s Physician: Phone:

Address:

Child’s Dentist: Phone:

Address:

Hospital of Preference:

**Authorization for Medical Care** (This must be witnessed)**.**

If I CANNOT be contacted in an emergency situation, or my child needs medical care, I authorize Bright Beginnings Childcare Center’s staff to obtain medical treatment for my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to include anesthesia, and any fees for these services are the responsibility of the parent/guardian.

Insurance Provider: Phone:

ID Number: Group Number

Insured Name: D.O.B.: SSN:

Printed Name:

Signature of Parent Guardian: Date:

Witnessed by: Date:

**Authorized Pick Up/Emergency Contacts if parent(s) cannot be reached**

**(List in order of contact):**

Authorized Pick Up/ Emergency Contact #1

Name: Relationship:

Driver’s License #:

Street Address:

City: State: Zip Code

Home Phone: Cell Phone:

Authorized Pick Up/ Emergency Contact #2

Name: Relationship:

Driver’s License #:

Street Address:

City: State: Zip Code:

Home Phone: Cell Phone:

Authorized Pick Up/ Emergency Contact #3

Name: Relationship:

Driver’s License #:

Street Address:

City: State: Zip Code

Home Phone:

Name: Relationship:

Driver’s License #:

Street Address:

City: State: Zip Code:

Home Phone: Cell Phone: