Stepping Stones
Discovery & Development Center

Enrollment Form

Child's Name:______________________________

Mother Name:______________________________

Father Name:______________________________

Address:__________________________________

City/Zip Code:_____________________/________

Mother's Employer:__________________________

Father's Employer:__________________________

Father's Address (if different):______________________

____

Nick Name:___________________________

Child's Birth date:_______________Sex:M F

Mother's Cell:__________________________

Father's Cell:__________________________

Mother's work#:________________________

Father's work#:_________________________

Home Phone:___________________________

Other Phone:___________________________

Email:_________________________________

Weekly Care Schedule

Start Date:___________________________

Monday:_____________________________

Tuesday:____________________________

Wednesday:__________________________

Thursday:___________________________

Friday:_______________________________

maximum hour for full time 47.5 hours a week (9.5 hrs a day)

Medical Contacts

Child's Doctor:__________________________

Address:_______________________________

Phone:_________________________________

Child's dentist:__________________________

Address:_______________________________

Phone:_________________________________

Emergency Contacts

Name:_______________________________

Address:_____________________________

Phone:______________________________

Relationship:__________________________

Is this person authorized to make medical decisions for your child if you can't be reached? Y N

Name:_______________________________

Address:_____________________________

Phone:______________________________

Relationship:__________________________

Is this person authorized to make medical decisions for your child if you can't be reached? Y N

Authorized Pick-up

Name:_________________________________

Address:_______________________________

Phone:_________________________________

Relationship:____________________________

Name:_________________________________

Address:_______________________________

Phone:_________________________________

Relationship:____________________________

Note: Any person unfamiliar to staff will be required to show a picture ID.

Limitations

Please indicate any limitations, restrictions, or concerns you may have for your child (ie. Allergies, medications, medical conditions, ect.)____

____

____

I authorize Stepping Stones Discovery & Development Center Staff to obtain emergency medical treatment for my child should the need arise. I assume all financial responsibility that may be required for treatment. To the best of my knowledge the information provided above is accurate.

Parent/ Guardian Signature:____________________________________Date:____________