Enrollment Form

For office use only
Start date: _____

Child Information

Last_____ First _____ Middle: _____
Name the student goes by: _____ ☐ Male ☐ Female
Date of Birth: _____ Age on September 1, 2014: _____

Parent/Guardian Information

Parent/Guardian (This is the 1st person we will contact in case of emergency)

Name _____
Relationship to Child _____
Home Address _____
_____
PRIMARY PHONE _____
(This is the 1st phone number we will use in case of emergency)
Additional Phone _____
E-Mail _____
If separated or divorced, who has primary custody? _____
_____

Programming Options for 2 and 3 year olds

Please choose which hours your child is enrolling in: ☐8:30-2pm ☐8:30-12:30 pm

If your child is *3 years old* on Sept 1st, please choose a program:

☐ 3-Day (Tues, Wed, Thurs)
☐ 4-Day (Mon, Tues, Wed, Thurs)

If your child is *2 years old* on Sept 1st, please choose a 2 year old program:

☐ 2-Day (Tues, Thurs)
☐ 3-Day (Tues, Wed, Thurs)

_____

Family Information

Other Children in Family:
Name: _____ Age: _____Name: _____Age:_____
Name: _____ Age: _____Name: _____Age:_____
Other Adults in Household:
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Emergency Contact

Name of local person to call in case of emergency if parents cannot be reached:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Release Authorization

I hereby authorize A Child's Place to allow my child to leave A Child's Place with the following persons:

Name: _____ Phone: _____

Name: _____ Phone: _____

_____

Authorization of Emergency Medical Attention

If I cannot be reached to arrange emergency medical attention at the time of illness or accident, I hereby authorize the A Child's Place staff to take my child to the nearest hospital. I give consent for necessary emergency treatment when my child is in the care of this hospital and/or physician.

Name of Physician: _____ Phone Number: _____

Address: _____

Name of Hospital: _____ Phone Number: _____

Address: _____

Signed:_____ Date:_____

_____

I authorize my child to participate in the following

- Water play activities
- School photographs for school publications, the website and the private Shutterfly site
- Student Directory

Parent Signature: _____

Hearing & Vision Screening

I understand that it will be the parent's responsibility to have all 4 and 5 year-old children tested for vision and hearing with their pediatrician.

Parent Signature: _____

How did you hear about ACP/ who referred you to our school? _____

SPECIAL INSTRUCTIONS/ ALLERGIES/ LONG-TERM CONTINUOUS MEDICATIONS: My child has these special problems or needs: (include any allergy, existing illness, previous serious illness, hospitalization in the last 12 months, and any medication prescribed for long-term, continuous use.)
(Please specify N/A if none)

_____

_____