Child's Name:		
Registering for:		
	2.5 - 3 Year Old Class	
]	☐ 4 - 5 Year Old Class	
Sex: Age:	Date of Birth:	
	/ /	
Home Address:	City: State: Zip code:	
Email:		
Father's Name:	Address (If different)	
Father's Place of Employment:	Phone Number:	
Employer's Address:	City: State: Zip code:	
Mother's Name:	Address (If different)	
Mother's Place of Employment:	Phone Number:	
Employer's Address:	City: State: Zip code:	
Child's living arrangements ( check one): ( ) Both parents ( ) Father ( ) Mother ( ) Other:		
Child's Legal Guardians (check one): () Both parents () Father () Mother () Other:		
The child may be released to the person(s) signing this agreement or to the following:		
*Name:	Address:	
Telephone Number:	Relationship to Parent or Child:	
*Name:	Address:	
Telephone Number:	Relationship to Parent or Child:	

Person to contact in the case of emergency when parent or guardian cannot be reached:         Name:       Telephone Number:         Name:       Telephone Number:         Name:       Telephone Number:         Octor's Doctor:       Doctor's Phone Number:         Doctor's Clinic Name:       My Child has the following special Needs:         My Child has the following special Needs:       My Child has the following special Needs:         My child is currently on medication(s) may be required to most effectively meet my child's needs while at the center:         My child is currently on medication(s) prescribed for long-term continuous use and/or has the following preexisting illness, allergies, or health concerns:         Should (child's name)       Date of birth         suffer an injury or illness while in the care of Sunlight Bilingual Preschool and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I (We) shall assume responsibility for payment for services         Parent Guardian:       Signature         Date:       Eduction (Child's name)         Date:       Signature			
Name:       Telephone Number:         Name:       Telephone Number:         Child's Doctor:       Doctor's Phone Number:         Doctor's Phone Number:       Doctor's Clinic Name:         My Child has the following special Needs:       Image: Clinic Name:         My Child has the following special Needs:       Image: Clinic Name:         My Child has the following special Needs:       Image: Clinic Name:         My child is currently on medication(s) may be required to most effectively meet my child's needs while at the center:       Image: Clinic Name:         My child is currently on medication(s) prescribed for long-term continuous use and/or has the following prexisting illness, allergies, or health concerns:       Date of birth			
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Date:	Parent Guardian:		
		Signature	
Facility Administrator:	Date:		
	Facility Administrator:		