Imagination Childcare Academy

**ENROLLMENT APPLICATION**

|  |  |  |
| --- | --- | --- |
| **BASIC INFORMATION** | | |
| ADMISSION DATE | DISCHARGE DATE | |
| GENDER | BIRTHDATE | |
| CHILD’S NAME | | |
| CHILD’S ADDRESS (Street, City, State, Zip) | | |
| PARENT/GUARDIAN MARITAL STATUS: ❏ single ❏ married ❏ divorced ❏ widowed | | |
| PRIMARY RESIDENCE: ❏ Mother ❏ Father ❏ Both ❏ | | |
| **PRIMARY CONTACT AND RELEASE PERSONS** | | |
| PARENT / GUARDIAN #1 NAME | | HOME PHONE |
| ADDRESS (Street, City, State, Zip) if not same as child’s | | CELL PHONE |
| EMAIL |
| EMPLOYER | | WORK SCHEDULE |
| EMPLOYER (street, city, state, zip) | | WORK PHONE |
|  | | |
| PARENT /GUARDIAN #2 NAME | | HOME PHONE |
| ADDRESS (Street, City, State, Zip) if not same as child’s | | CELL PHONE |
| EMAIL |
| EMPLOYER | | WORK SCHEDULE |
| EMPLOYER (street, city, state, zip) | | WORK PHONE |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **FAMILY MEMBERS YOUR CHILD LIVES WITH** | | | | | |
| NAME | | AGE | | RELATIONSHIP | |
| NAME | | AGE | | RELATIONSHIP | |
| NAME | | AGE | | RELATIONSHIP | |
| NAME | | AGE | | RELATIONSHIP | |
| NAME | | AGE | | RELATIONSHIP | |
| NAME | | AGE | | RELATIONSHIP | |
| **EMERGENCY CONTACTS AND RELEASE PERSONS** | | | | | |
| Please list the persons you would like contacted (in order of priority) if you cannot be reached in case of an emergency. Check the “Emergency Contact and Release” box, if the persons listed will also be authorized to pick up the child for purposes of medical treatment. Additionally, please list the persons you would like to be authorized for pick-up only on a given day (i.e. babysitter). For these persons, check the “Release Only” box. For the safety of your child, we will request all authorized release persons with whom staff are not familiar to provide Government- issued photo identification at the time of pick-up. | | | | | |
| NAME #1 (Mandatory) | | | RELATIONSHIP TO CHILD | | PHONE NUMBERS  Cell:  Work:  Home: |
| Emergency Contact and Release ❏ | Release Only ❏ | |
| ADDRESS (Street, City, State, Zip) | | | | |
| NAME #2 (Optional) | | | RELATIONSHIP TO CHILD | | PHONE NUMBERS  Cell,:  Work:  Home: |
| Emergency Contact and Release ❏ | Release Only ❏ | |
| ADDRESS (Street, City, State, Zip) | | | | |
| NAME #3 (Optional) | | | RELATIONSHIP TO CHILD | | PHONE NUMBERS  Cell:  Work:  Home: |
| Emergency Contact and Release ❏ | Release Only ❏ | |
| ADDRESS (Street, City, State, Zip) | | | | |
| If you want a person who is not identified above to pick up your child, you must notify the center staff in advance, in writing. Your child will not be released without prior authorization. In the event you call pick-up authorization into the center because you are unable to submit your authorization in writing, we will use your personal information from the packet to verify your identity.  For all children’s safety, it is crucial to use your secured access to enter the building and to sign your child in upon entry. To ensure the safety of our center’s staff and children, please do not share your secured access with anyone else. If you must pick up your child after closing time, you will be charged a late fee of $10 for every 10 minutes that you are late. This fee begins promptly at 6:00 PM. | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CHILD’S PROJECTED ATTENDANCE SCHEDULE** | | | | |
| HOURS OF OPERATION MONDAY-FRIDAY 7AM-6PM | | | | |
| Days  (Check all days that child will attend) | | Drop Off Time | | Pick Up Time |
| MON | ❏ | ❏AM ❏PM | | ❏AM ❏PM |
| TUES | ❏ | ❏AM ❏PM | | ❏AM ❏PM |
| WED | ❏ | ❏AM ❏PM | | ❏AM ❏PM |
| THURS | ❏ | ❏AM ❏PM | | ❏AM ❏PM |
| FRI | ❏ | ❏AM ❏PM | | ❏AM ❏PM |
| **AUTHORIZATION FOR EMERGENCY MEDICAL CARE** | | | | |
| I understand that I will be notified at once in case of an emergency with my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice.  If I cannot be reached to make necessary arrangements, or in a critical emergency requiring medical care, I authorize a representative from Imagination Childcare Inc. to contact any of the following: | | | | |
| PHYSICIAN ‘S NAME | | | PHONE NUMBER | |
| DENTIST’S NAME | | | PHONE NUMBER | |
| PREFERRED HOSPITAL NAME | | | PHONE NUMBER | |
| HEALTH INSURANCE PROVIDER | | | POLICY NUMBER | |
| SECONDARY HEALTH INSURANCE PROVIDER | | | POLICY NUMBER | |

