

Instructions to parent: Complete all items on this form. Sign and date where indicated. If your child has a medical condition which might require care, please list it. If necessary, have your child’s health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY. OPEN ENROLLMENT IS YEAR-ROUND.

# Enrollment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hours & Days of Expected Attendance: \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Information**

**Mother/Guardian**  First Name: M.I. Last Name:

Address:

Occupation: Home Phone: ( )

Employed By: Office Phone: ( )

Work Address: Work Hours: Cell Phone: ( )

[ ] Custodial Parent (If married, mark both parents) Mother’s SS#:

Email: Driver’s License #:

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Father/Guardian**  First Name: M.I. Last Name:

Address:

Occupation: Home Phone: ( )

Employed By: Office Phone: ( )

Work Address: Work Hours: Cell Phone: ( )

[ ] Custodial Parent (If married, mark both parents) Father’s SS#:

Email: Driver’s License #:

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child Information**

**1st Child**  First Name: M.I. Last Name:

Name child prefers to be called:

Child’s Address: \_\_\_\_\_\_\_

Gender: [ ] Male [ ] Female Date of Birth:

List any existing medical conditions, medication and/or special attention your child may require? Does your child have an IFSP/ IEP? Circle Yes or No (Can you please provide us with a copy, so we may support optimal outcomes for your child and family. Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pediatrician’s Name: Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Health Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Photographs: May we take and maintain a photo of your child for security purposes? [] Yes [ ] No

 **2nd Child**  First Name: M.I. Last Name:

Name child prefers to be called:

Child’s Address: \_\_\_\_\_\_\_\_

Gender: [ ] Male [ ] Female Date of Birth:

List any existing medical conditions, medication and/or special attention your child may require? Does your child have an IFSP/ IEP? Circle Yes or No (Can you please provide us with a copy, so we may support optimal outcomes for your child and family.)

Allergies:

Pediatrician’s Name: Phone: ( )

Name of Health Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Photographs: May we take and maintain a photo of your child for security purposes? [ ] Yes [ ] No

 **3rd Child**  First Name: M.I. Last Name:

Name child prefers to be called: Grade/Class:

Child’s Address: \_\_\_\_\_\_\_\_

Gender: [ ] Male [ ] Female Date of Birth: \_\_\_

List any existing medical conditions, medication and/or special attention your child may require? Does your child have an IFSP/ IEP? Circle Yes or No (Can you please provide us with a copy, so we may support optimal outcomes for your child and family.)

Allergies:

Pediatrician’s Name: Phone: ( )

Name of Health Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Photographs: May we take and maintain a photo of your child for security purposes? [ ] Yes [ ] No

**Please complete all attached forms and return it with your one week of tuition deposit and curriculum fee of $100.00. Please make sure all medical forms are complete and signed by your child’s health practitioner.**

**Thank you!**