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 littleangelscc@gmail.com

ENROLLMENT RECORD

Admission date: _____

Child Name:	
Address:	
Home Phone:	
Date of birth:	Age:
Child lives with:	
Both parents <input type="checkbox"/>	Mom <input type="checkbox"/> Dad <input type="checkbox"/> Guardian <input type="checkbox"/>
Mother Name:	
Home Address:	
Workplace:	
Phone Work:	Cell Phone:
Email:	
Father Name:	
Home Address:	
Workplace:	
Phone Work:	Cell Phone:
Email:	
Name of Physician:	
Address:	
Phone Number:	
Emergency contact person if parent is unavailable	
Name:	Relationship:
Address:	
Phone Number:	

List of people other than parents who are authorized to pick the child up. Children Will ONLY be released to a parent or guardian or to a person designated by parent after verification of ID	
Name(Nombre)	Phone(Tel.)
Name(Nombre)	Phone(Tel.)
Special Instructions: such as environmental allergies, food intolerance and any other information which caregivers should be aware of:	
Does your child have diagnosed food allergies? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, plan submitted on:	
Authorization for emergency medical attention	
In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize Little Angel's Child Care in charge to take my child to:	
Name of Physician:	
Address:	
Phone number:	
Name of Emergency Care Facility:	
Address:	
Phone number:	

I give consent for this facility to secure any and all necessary emergency medical care for my child.

Parent or Guardian

Date

Attach copy of Immunization (Anexar copia de Vacunas)