
ORGANIZATION NAME

PROGRAM YEAR

CHILD CARE ENROLLMENT FORM

For Parents/Guardians to Complete

Participants' Name: _____

Date of Birth: _____

Participants' Home Address: _____

Participants' Home Phone: _____

Mother's Name: _____

Home Phone: _____

Mother's Employer & Address: _____

Work Phone: _____

Work Hours: _____

Father's Name: _____

Home Phone: _____

Father's Employer & Address: _____

Work Phone: _____

Work Hours: _____

Hours of Care Needed: _____

Days: Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Meals Needed: Breakfast AM Snack Lunch PM Snack Supper

Special Needs of Participants: _____

Medical Information: (Allergies, Sickness) _____

NAMES OF TWO OTHER PERSONS WHO CAN BE CONTACTED IN CASE OF AN EMERGENCY

NAME _____

NAME _____

ADDRESS _____

ADDRESS _____

CITY _____

CITY _____

PHONE # _____

PHONE # _____

Parent's Signature _____

Date Signed _____

For Provider or Center to Complete

Enrollment Date _____
Withdrawal Date _____

Participants 's Age _____
Reason for Withdrawal _____