Enrollment Application

1001 Marie Avenue
South Saint Paul MN 55075
PHONE: 651.552.1265

WEB: www.mapletreedayschool.com

Office Use Only:
Reg Date:____________
Reg Check#__________
Amt:________________
Ck Date: ____________

Child's Name:____
First, Middle, Last Name (This is the name by which we will address your child & label their belongings)

Address:____
(Street) (City) (Zip)

Birthdate:______________________________ **Age as of Sept. 1st** ________/__________ **Sex: M / F**
(M/D/Y) (years) (months)

Parent/Guardian:	**Parent/Guardian:**
Address: (Street, City, State, Zip)	**Address: (Street, City, State, Zip)**
E-mail Address:	**E-mail Address:**
Home Phone:	**Home Phone:**
Cell Phone:	**Cell Phone:**
Employer:	**Employer:**
Work Phone:	**Work Phone:**

Programming: *Please check child's age group and circle the number of days to attend. If choosing less than five day programming specify by circling which days of the week to attend.*

☐ **TODDLERS: 16-24 MONTHS AS OF SEPTEMBER 1**

5 Day - 4 Day - 3 Day... If 3 or 4 days, specify days: M T W TH F

☐ **PRE-1: 33 MONTHS TO 3.11 YEARS AS OF SEPTEMBER 1**

Full Day .... 5 Day - 4 Day - 3 Day ... If 3 or 4 days, specify days: M T W TH F

☐ **Pre-K: 4 YEARS AS OF SEPTEMBER 1**

Full Day .... 5 Day - 4 Day - 3 Day ... If 3 or 4 days, specify days: M T W TH F

START DATE: ______________________________

____ **Date:**________________________**(over)**

Signature of Parent(s) or legal guardian(s)

CONTACT PEOPLE

Please list **two people other than parents** authorized to:

- pick up your child from Maple Tree Day School,
- can take responsibility for your child in case of an emergency,
- can pick up your child should he/she becomes ill at school and you cannot be reached.

Please list people who can be reached during the day. Note: Individuals authorized to pick up your child **must live locally**.

Name:____ Relationship:____

Address:____ Phone:__________________________

Name:____ Relationship:____

Address:____ Phone:__________________________

CHILD'S USUAL SOURCE OF MEDICAL CARE

Physician's Name: ____ Phone:__________________________

Address:____

(Street, City, State, Zip)

Dentist:____ Phone:___________________________

Address:____

(Street, City, State, Zip)

Hospital Name: ____Phone:__________________________

Address:____

(Street, City, State, Zip)

Child's Health Insurance: ____

Subscribers Name (on insurance card):__________________________________ID#:_____________________________

Allergies: ____

Dietary Restrictions: ____

Is your child toilet trained? ____(Child must be walking unassisted.)

Does your child require a nap? ____

Please describe your child's eating, communication, comforting habits/methods: ____________________________

____

____

Specific instructions of special conditions, disabilities: ____

____

Regarding the child's "Health Care Summary" and "Immunization Record" who exactly is authorized to have access to the health information about your child? ____

____

As a parent/legal guardian, I give consent to Maple Tree Day School to administer to my child emergency first aid by the program staff. I understand that if necessary, 911 will be called and, my child may be transported to receive emergency care. I understand that I will be responsible for all emergency transportation and any charges not covered by insurance. I give consent for the emergency contact persons listed above to act on my behalf until I am available. I agree to update this information when a change occurs. Parent/Guardian Signatures:

#1 ____Date:__________________________

#2 ____Date:__________________________