



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

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: _____