



\$25 APPLICATION FEE IS NON-REFUNDABLE

Orientation Date _____
Application Date _____
Enrollment Date _____
Termination Date _____

CHILD CARE APPLICATION

Child's Full Name _____ M__ F__
(Last) (First) (MI)

Birthdate _____

Mother's Name _____ Home Phone _____

Address _____ Zip Code _____

email _____

Employment _____ Work Phone _____

Beeper/Cell Phone Number _____ Email Address _____

Father's Name _____ Home Phone _____

Address _____ Zip Code _____

email _____

Employment _____ Work Phone _____

Beeper/Cell Phone Number _____ Email Address _____

Emergency Care Information:

Name of Child's Doctor _____ Office Phone _____

Address _____

Name of Child's Dentist _____ Office Phone _____

Hospital Preference _____

If neither father nor mother (or guardian) can be contacted in case of emergency, call:

Name _____ Home Phone _____ Office Phone _____

Relationship to Child _____

Name _____ Home Phone _____ Office Phone _____

Relationship to Child _____

I agree that the director may authorize the physician of his/her choice to provide emergency care in the event that neither I nor the family physician can be contacted immediately.

(Signature of Parent)

(Date)

Please list other persons authorized to pick up your child and t their relationship to your child:

(Name/Relationship) _____
(Phone)

(Name/Relationship) _____
(Phone)

(Name/Relationship) _____
(Phone)

(Name/Relationship) _____
(Phone)

(Name/Relationship) _____
(Phone)