$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)