



**Enrollment Form
Early Care Program
Annual Registration Fee**

\$25.00 per student

Weekly Fees

\$35.00 a week (1 child)
\$40.00 a week (2+ children)

Breakfast will be served from 6:15 AM-7:30 AM

Hours: 6:15 AM-7:30 AM

Date of Enrollment: _____

Please Print

Child's Name: _____

Nickname: _____

Contact Information:

Mother's Name: _____

Father's Name: _____

Mailing Address: _____

Home Phone: _____

(Mother) Work Phone: _____

(Mother) Cell Phone: _____

(Father) Work Phone: _____

(Father) Cell Phone: _____

Emergency Contact Information:

Emergency Contact Person #1: _____

Emergency Contact Person #1 Phone: _____

Emergency Contact Person #2: _____

Emergency Contact Person #2 Phone: _____

Doctor's Name/Phone Number: _____

Does your child have any known allergies?

Has your child had the following common childhood illnesses? (Please circle)

Constipation Asthma Convulsions Fainting Spells
Bronchitis Frequent Ear Infections Diabetes

Does your child have any speech, hearing, or visual problems?

About Your Child

Has there been any recent traumatic situation the child has been exposed to such as a death in the family, divorce, new sibling, etc.?

What is your child's temperament? Are they easy going, hard to please, demanding, aggressive, etc.?

Does your child have any food restrictions?

Can your child be relied upon to indicate bathroom wishes? Yes _____ No _____

Are there any siblings? Please name them and specify ages and gender.

Name: _____ Age: _____ Gender: _____

Name: _____ Age: _____ Gender: _____

Name: _____ Age: _____ Gender: _____

What language(s) are spoken at home? _____

Are there any other comments or information you would like to let me know about?
