

Mailbox number: _____

APPLICATION / RECORD OF CHILD INFORMATION

Name of Child: _____

Address: _____

Birth date: _____ Sex: _____ Male / Female

Admission Date: _____ Withdrawal Date: _____

PARENT OR OTHER PERSON(S) PLACING THE CHILD

Name: _____ Name: _____

SS#: _____ SS#: _____

Relation to child: _____ Relation to child: _____

Home address: _____ Home address _____

Home Number: _____ Home Number: _____

Cell Number: _____ Cell Number: _____

Place of Employment: _____ Place of Employment: _____

Work Address: _____ Work Address: _____

Work Number: _____ Work Number: _____

Working Hours: _____ Working Hours: _____

Email Address: _____

EMERGENCY CONTACT / RELEASE PERSON(S)

Name: _____ Relationship to child: _____

Address: _____

Best Contact Number: _____

Name: _____ Relationship to child: _____

Address: _____

Best Contact Number: _____

NAME OF CHILD'S PHYSICIAN / MEDICAL CARE PROVIDER

Name: _____ Phone Number: _____

Hospital or Clinic: _____

Address: _____

Coverage name for Child: _____ Policy Number (Required): _____

PROGRAM

Days per week: _____ Average Hours of Care: _____

Weekly Rate of pay: _____ Monthly Rate of Pay: _____

PARENT'S SIGNATURE IS REQUIRED ON ALL THREE LINES BELOW FOR CONSENT

Signature of Parent / Guardian

Date

Signature for Administration of Minor First-Aid Procedures

Signature for Obtaining Emergency Medical Care

THIS APPLICATION MUST BE ACCOMPANIED BY A NON-REFUNDABLE REGISTRATION FEE OF \$ _____