

CHILD ENROLLMENT

PERSONAL INFORMATION

Enrollment Date:

Name Of Child:	<input type="text"/>		Date Of Birth:	<input type="text"/>
Gender	<input type="radio"/> Male	<input type="radio"/> Female		

PARENT/GUARDIAN INFORMATION

Please check the box (☐) to indicate the primary residence of the child listed above.

PARENT/GUARDIAN # 1 ☐

PARENT/GUARDIAN # 2 ☐

Name:	<input type="text"/>	Name:	<input type="text"/>
Relationship:	<input type="text"/>	Relationship:	<input type="text"/>
Cell Phone:	<input type="text"/>	Cell Phone:	<input type="text"/>
Email:	<input type="text"/>	Email:	<input type="text"/>
Home Address:	<input type="text"/>	Home Address:	<input type="text"/>
Employer Name:	<input type="text"/>	Employer Name:	<input type="text"/>
Employer Phone:	<input type="text"/>	Employer Phone:	<input type="text"/>
Employer Address:	<input type="text"/>	Employer Address:	<input type="text"/>

EMERGENCY CONTACTS

Persons authorized to pick up your child and/or contact in case of emergency if neither parent is available to assume responsibility for the child.

Contact Name #1:	<input type="text"/>	Contact Name #2:	<input type="text"/>	Contact Name #3:	<input type="text"/>
Relationship:	<input type="text"/>	Relationship:	<input type="text"/>	Relationship:	<input type="text"/>
Phone:	<input type="text"/>	Phone:	<input type="text"/>	Phone:	<input type="text"/>
Employer Phone:	<input type="text"/>	Employer Phone:	<input type="text"/>	Employer Phone:	<input type="text"/>

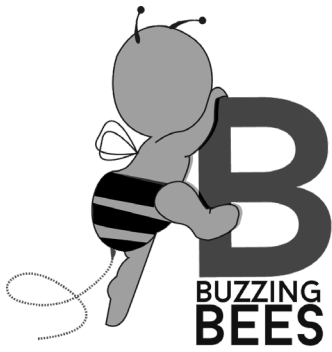
DEPARTING TIME

What time of day may we expect your child to arrive and depart?

Mon : - :
 Tue : - :
 Wed : - :
 Thur : - :
 Fri : - :

PHYSICIAN'S INFORMATION

Name of Child's Physician:	<input type="text"/>	Physician's Phone Number:	<input type="text"/>
Address of Physician:	<input type="text"/>		



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HEALTH STATEMENT

As the parent/guardian of the above named child, I certify that he/she is in good physical health and may participate in the normal activities of the program and has no conditions or specific needs that require specific accommodations, unless otherwise indicated in the medical information provided above or an attached Universal Health Record or a Care Plan for Children with Special Health Needs.

Parent/Guardian Initials: _____

EMERGENCY TREATMENT

As the parent(s)/ legal guardian(s) of the above named child, I (we) attest that the information above is correct. I (we) authorize the child care center staff to obtain emergency treatment for my child and understand that I (we) shall be promptly notified.

Parent/Guardian Initials: _____

PHOTOGRAPHS

PHOTOGRAPHS: May we have permission to take photographs of your child in the classroom to be used on our **social media, website, class dojo, bulletin boards, newsletters and other events only pertaining** to Buzzing Bees? Yes No

WALKING TRIPS WITHIN THE COMMUNITY

May we have permission to take your child on neighborhood walks? Yes No

POLICY AGREEMENT: In applying to reserve child care services for my child, I agree to abide by the policies of the Parent Contract and/or Parent Handbook. In the event that I should desire to withdraw my child from Buzzing Bees program, I agree to give written notice to the Director.

Today's Date: _____

Desired Entry Date: _____

Parent's Signature (1): _____

Parent's Signature (2): _____

OFFICE USE ONLY

Enrollment Date: _____ Classroom: _____