

**Office of Early Learning and School Readiness**

CHILD ENROLLMENT INFORMATION

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Employer name & address \_\_\_\_\_ Work Phone \_\_\_\_\_

Please check which phone number should be used 1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup> to reach you while your child is in the program.

Cell  1  2  3                      Home  1  2  3                      Work  1  2  3

Employer Address \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Employer name & address \_\_\_\_\_ Work Phone \_\_\_\_\_

Please check which phone number should be used 1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup> to reach you while your child is in the program.

Cell  1  2  3                      Home  1  2  3                      Work  1  2  3

Please list two people to be contacted in the event of an emergency if the parent cannot be contacted:

Name	Name
Street Address	Street Address
City	City
State                      Zip Code	State                      Zip Code
Relationship to Child	Relationship to Child
Home phone:	Home phone:
Cell phone:	Cell phone:
Work phone:	Work phone:

Physician:

Dentist:

Name	Name
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code
Phone	Phone

(over)

**ANNUAL CLASS ROSTER**

Each year we prepare a roster for each group of children in our program.  
 This roster will not be furnished to any persons other than parents of children enrolled in our program.

I authorize the following to be listed on the parent roster:

My child's name	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Parents/Guardians name	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Phone number	<input type="checkbox"/> Work <input type="checkbox"/> Mobil <input type="checkbox"/> Home	<input type="checkbox"/> No

\_\_\_\_\_  
*Signature of parent, or guardian*

\_\_\_\_\_  
*Date*

CHRONIC PHYSICAL PROBLEM(S): _____
HISTORY OF HOSPITALIZATION: _____
DISEASES THIS CHILD HAS HAD: _____ _____
ALLERGIES AND TREATMENT: _____ _____
MEDICATIONS, FOOD SUPPLEMENTS, MODIFIED DIET OR FLUORIDE SUPPLEMENTS: _____ _____

List of Person(s) to whom this child can be released: (Please print)

_____
_____
_____

List of Person(s) not permitted to pick up this child (Please print)

_____	Restraint papers or Divorce decree attached
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**IMPORTANT: Please attach a copy of your child's immunization records**

EXEMPT FROM IMMUNIZATIONS	
Religious conviction	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other: _____ _____ _____	

Parent/Guardian signature for immunization exemption:  
 \_\_\_\_\_