



Enrollment Form

Registration Date: _____

Child's Name: _____ Gender: _____

Nickname: _____ Birthdate: _____ Start Date: _____

Mother's name: _____

Home Address: _____

Employer: _____

Home Phone: _____ Work Phone: _____ Cell Phone _____

E-mail address: _____

Father's name: _____

Home Address: _____

Employer: _____

Home Phone: _____ Work Phone: _____ Cell Phone _____

E-mail address: _____

Person/s with whom the child lives: _____

Child's Physician: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

In case of an emergency, or if I cannot be contacted to pick up my child, I hereby authorize Little Ones Learning Center to contact the following person (s):

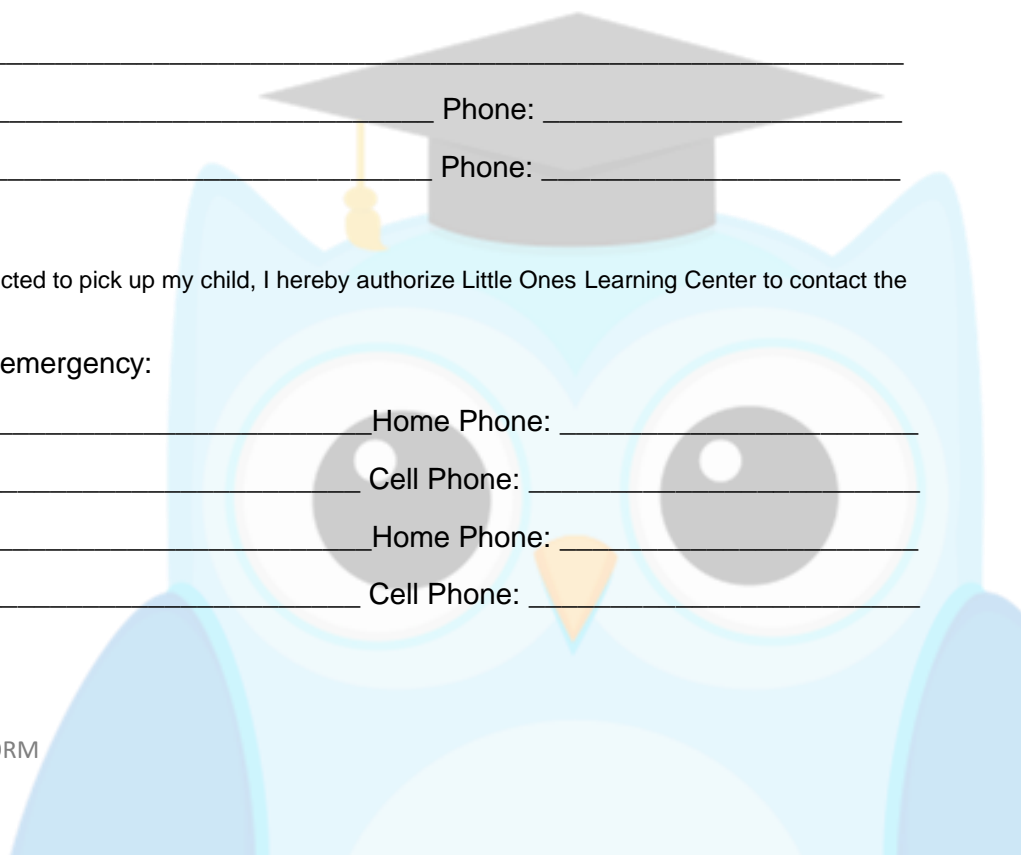
Individuals to contact in the case of an emergency:

Name: _____ Home Phone: _____

Relationship to child _____ Cell Phone: _____

Name: _____ Home Phone: _____

Relationship to child _____ Cell Phone: _____





My child has permission to be released to the following individuals or transportation services in addition to the emergency contact persons listed above. (Please notify all individuals that they may be asked to show proof of identity)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Does your child have any food allergies? NO YES _____

Does your child have any dietary restrictions? NO YES _____

Does your child have any special needs? NO YES _____

Days Attending

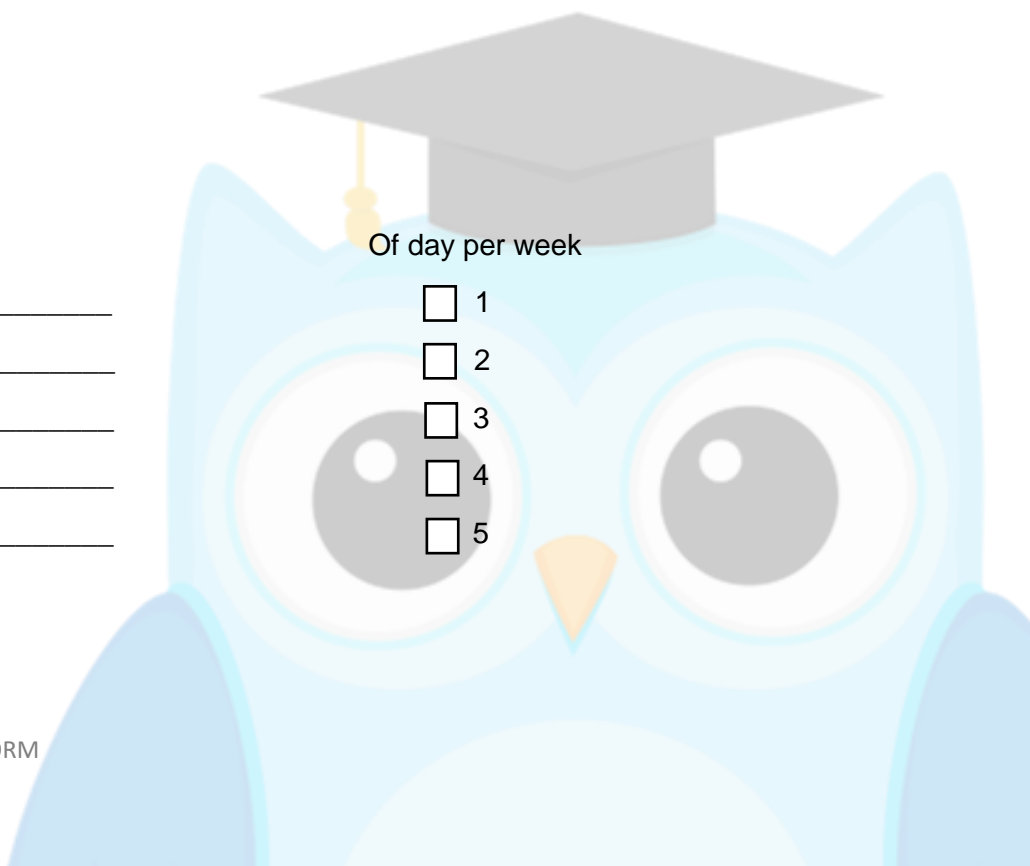
- Full Time
- Part Time
- After School

Days Attending

- | Days Attending | Hours |
|------------------------------------|----------------|
| <input type="checkbox"/> Monday | _____ to _____ |
| <input type="checkbox"/> Tuesday | _____ to _____ |
| <input type="checkbox"/> Wednesday | _____ to _____ |
| <input type="checkbox"/> Thursday | _____ to _____ |
| <input type="checkbox"/> Friday | _____ to _____ |

Of day per week

- 1
- 2
- 3
- 4
- 5





I understand my child will be dismissed if I do not provide the center with a current immunization certificate at all times.

I authorize this program and its representatives to get emergency medical treatment for my child if necessary.

Date: _____

Parent / Guardian Signature:

Parent / Guardian Printed Name:

Little Ones Administration Signature

