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 $_____