

ENROLLMENT FORM



After School Program
EDUCATIONAL ENRICHMENT
(770) 875-0001

Entrance Date _____ Withdrawal Date _____

Child's Name _____ Sex _____ Age _____ Date of birth _____

Home Address (Street) _____

City _____ State _____ Zip _____

Home Phone Number _____

Father's Name _____ Home Phone Number _____

Father's Home Address (if different from child's) Street _____

City _____ State _____ Zip _____

Father's Place of Employment _____ Work Phone _____

Employer's Street Address _____ City _____ State _____ Zip _____

Mother's Name _____ Home Phone Number _____

Mother's Home Address (if different from child's) Street _____

City _____ State _____ Zip _____

Mother's Place of Employment _____ Work Phone # _____

Employer's Street Address _____ City _____ State _____ Zip _____

Child's Living Arrangements: (check one) Both Parents Mother Father Other

Child's Legal Guardian(s): (check one) Both Parents Mother Father Other

The child may be released to the person(s) signing this agreement or to the following:

*Name _____ Address _____
(Street-City-State-Zip)
Telephone Number _____ Relationship to child _____
Relationship to Parent(s) or Guardian _____
Other identifying information (if any) _____

*Name _____ Address _____
(Street-City-State-Zip)
Telephone Number _____ Relationship to child _____
Relationship to Parent(s) or Guardian _____
Other identifying information (if any) _____

Persons to contact in the case of emergency when parent or guardian cannot be reached:

Name _____ Telephone Number _____

Name _____ Telephone Number _____

Name _____ Telephone Number _____

Name of Public or Private School child attends, if any: _____

Child's doctor or clinic name _____

Doctor/clinic phone # _____

My child has the following special needs _____

The following special accommodation(s) may be required to most effectively meet my child's needs while at the center: _____

My child is currently on medication(s) prescribed for long-term continuous use and/or has the following pre-existing illness, allergies, or health concerns: _____

EMERGENCY MEDICAL AUTHORIZATION

Should (child's name) _____ Date of birth _____
suffer an injury or illness while in the care of (Facility name) _____
and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention
and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

Parent/Guardian: _____

Signature

Date: _____

Facility Administrator/Person-In-Charge _____

Signature

Date: _____