



# CHILD'S ENROLLMENT RECORD

**DIRECTOR'S USE ONLY**

Date enrolled \_\_\_\_\_

Child's Full Legal Name \_\_\_\_\_  
*First Middle Last Nickname*

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Primary Hours of Care From \_\_\_\_\_ To \_\_\_\_\_ Days of Week in Care \_\_\_\_\_

Child's Physical Address \_\_\_\_\_  
*Street Address (number, apartment #, street) City State Zip Code*

**Family Information:**

Child Lives with \_\_\_\_\_

Parent's Name \_\_\_\_\_  
*First Middle Initial Last*

Parent's Name \_\_\_\_\_  
*First Middle Initial Last*

Address: \_\_\_\_\_

Address: \_\_\_\_\_

*City State Zip Code*

*City State Zip Code*

Home Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

*City State Zip Code*

*City State Zip Code*

Parent's Date of Birth \_\_\_\_\_

Parent's Date of Birth \_\_\_\_\_

Work Phone \_\_\_\_\_ Other \_\_\_\_\_

Work Phone \_\_\_\_\_ Other \_\_\_\_\_

Parent's email \_\_\_\_\_

Parent's email \_\_\_\_\_

Custody: Mother \_\_\_\_\_ Father \_\_\_\_\_ Both \_\_\_\_\_ Other \_\_\_\_\_ Name \_\_\_\_\_

**Emergency Contacts:**

Child will be released only to the custodial parent or legal guardian and the persons listed below. The following people will also be contacted and are authorized to remove the child from the children's center in case of illness, accident or emergency, **if for some reason the custodial parent(s) or legal guardian(s) cannot be reached:**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_  
*Street Address (number, apartment #, street) City State Zip Code*

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_  
*Street Address (number, apartment #, street) City State Zip Code*

**Please use additional sheet of paper to list name, address and phone number of any other people authorized to pick the child up.**

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**Medical Information:**

**Child's Physician/Health Resource** \_\_\_\_\_

Telephone Number \_\_\_\_\_

Address \_\_\_\_\_  
*Street Address (number, apartment #, street) City State Zip Code*

**Hospital Preference** \_\_\_\_\_

**Name of Dentist** \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_  
*Street Address (number, apartment #, street) City State Zip Code*

**Meals typically served while in care:**      Breakfast      AM Snack      Lunch      PM Snack      Supper

**Emergency Care Plan Instructions (if applicable)** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MISCELLANEOUS INFORMATION**

List all known allergies \_\_\_\_\_

List all identifying scars, birthmarks, skin discolorations \_\_\_\_\_

Special medical or dietary needs of child \_\_\_\_\_

List any areas of concern \_\_\_\_\_

**My signature below verifies that:**

**I give permission to consult the child's physician/health resource listed above in case of emergency if parent/guardian cannot be reached.**

**I have received a copy of the "Know Your Child's Children's Center" brochure.**

**I was notified in writing of the disciplinary and expulsion policies used by the children's center.**

**I was provided the food and nutrition policies used by the children's center.**

**Your signature below indicates that you have received the above items and that the information on this enrollment form is complete and accurate. I hereby grant permission for the staff of this facility to have access to my child's records.**

\_\_\_\_\_  
**Signature of Custodial Parent or Legal Guardian**

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



EMERGENCY MEDICAL RELEASE

This form must contain only one child's name, and be the original notarized form.

A new notarized form is required when there is a change in legal guardianship.

Please Print Information

Child's Full Name: Birthdate:

Allergies:

Medicines Routinely Taken:

Name of Custodial Parent(s)/Legal Guardian(s):

Address: Street Address (number, apartment #, street) City State Zip Code

Home Telephone Cell Telephone Work Telephone

Family Physician's Name/Health Care Resource:

Address: Street Address (number, apartment #, street) City State Zip Code

Telephone ( )

Hospital Preference: Name City

Medical Insurance Company:

Policy #: Expiration Date:

Emergency Contact (if custodial parent/guardian cannot be reached):

Address: Street Address (number, apartment #, street) City, State, Zip Code

Home Telephone Cell Telephone Work Telephone



Sign in the presence of the Notary.

I hereby give my consent to any emergency facility and physician to administer necessary treatment to my child (Child's Full Name), in the event of an emergency at which time I cannot be reached. I give consent to transport by ambulance if situation warrants it.

Signature of Custodial Parent/Legal Guardian (Affiant)

STATE OF FLORIDA COUNTY OF

The foregoing instrument was acknowledged before me this (Month) (Day) 20 (Year)

by means of physical presence or online notarization by (Name of Affiant) who is personally known

to me or has produced (Type of identification) as identification.

SEAL OF NOTARY

Signed: (Signature of Notary)



## Food Experience Permission Form

I give permission for my child \_\_\_\_\_ to participate in food related activities.

Please check one of the following:

\_\_\_\_\_ My child DOES NOT have a food allergy or dietary restriction.

\_\_\_\_\_ My child DOES have a food allergy or dietary restriction. He or she may participate, but may not eat or handle the following items (please list below)

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\_\_\_\_\_ My child DOES have a food allergy or dietary restriction. He or she may not participate in activities.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date