



HOPE CHILDREN'S CENTER ENROLLMENT INFORMATION



Facility Name Hope Children's Center		Director's Name Shelley Cox	
Child's Full Name		Preferred Name	Date of Birth
			Gender M F
Child's Address	Street	City	Zip
Days & hours child will be in care	MWF 9:00a - 12:00p	TTh 9:30a - 1:30p	Home Telephone Number
	M-F 8:00a - 12:00p (Kinder)	M-F 9:00a - 12:00p (5-Day)	MWF 12:00p - 2:00p
Mother's Name	Father's Name	Guardian's Name	Address(if different)
Phone numbers while child is in care, if none put N/A: Mother's Work #: Mother's Cell #: Mother's Email:		Phone numbers while child is in care, if none put N/A: Father's Work #: Father's Cell #: Father's Email:	
Local person to call in emergency, if parents cannot be reached:			
Name:	Ph.#:	Relationship:	
Address	Street	City	Zip
I hereby authorize the child care facility to allow my child to leave the child care facility only with the following persons:			
Mother's Name:	Ph.#:		
Father's Name:	Ph.#:		
Name:	Ph.#:	Relationship:	
Name:	Ph.#:	Relationship:	
Name:	Ph.#:	Relationship:	

List any special problems your child may have, such as allergic reactions to medications, existing illness, previous serious illness or surgeries, injuries during the past 12 months, any medication prescribed for long-term continuous use, and any other information which staff should be aware of (including seizures, food or seasonal allergies, bee or insect sensitivities, etc.) If none, put N/A.

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event I cannot be reached to make arrangements for emergency medical attention, I authorize the facility Director or person in charge to take my child to:		
Name of Physician:	Address (street # and name)	Ph.#:
Name of Hospital:	Address (street # and name)	Ph.#:
I give consent to this facility to secure any and all necessary emergency medical care for my child.		
_____ Signature - Parent or Legal Guardian		

I understand that the Registration/Supply Fee and May tuition are non-refundable. In the event I choose to terminate enrollment at Hope Children's Center, thirty days written notice is required before I am released from my monthly tuition obligation.

 Signature - Parent or Legal Guardian

 Date

OFFICE USE ONLY		
Date of Admission _____	Date of Withdrawl _____	Fees Paid _____