

Schedule

Please list **projected consecutive nine hour period** for days in attendance:

Monday	Tuesday	Wednesday	Thursday	Friday

Other

Pick Up

In case of illness, accident, or emergency, the following persons may be notified and are authorized to pick up my child:

POSITIVE PHOTO IDENTIFICATION REQUIRED

1.	_____	_____	()	()
	Name	Address	Home Telephone	Cell Telephone
2.	_____	_____	()	()
	Name	Address	Home Telephone	Cell Telephone
3.	_____	_____	()	()
	Name	Address	Home Telephone	Cell Telephone

Additional

List any significant facts about your child's health or behavior:

Has your child had any other examinations prior to this time (neurological, speech, hearing, ophthalmological, psychological, etc.) Yes _____ No _____

If yes, indicate what examinations and results: _____

Does your child take any routine medications? Yes _____ No _____

If yes, please list: _____

I heard about Family Partn Direct Mail, TV, Billboard, Magazine Ad, Radio, Newspaper
 Personal Recommendation, Yellow Pages, Coupon, Other _____

The parent's or legal guardian's signature below acknowledges and/or verifies receipt of the following:

- Disciplinary practices used by the child care facility
- Authorization for Medication Policy
- DCF Physical and Immunization forms 3040 & 680 are due within two weeks of enrollment and must be kept current throughout enrollment
- "Know Your Child Care Center," CF/PI Publication 175-24, 06/2002
- Participation in periodic field trips permission

All information must be filled out to process registration.

Parent / Guardian Signature Date

Director Signature Date

<i>For Office Use Only</i>	
Enrollment: _____ / _____ / _____	Start: _____ / _____ / _____
Assigned to Area: _____	
Tuition Amount: _____	
Tuition Description: _____	
Registration Amount: _____	Paid: ____/____/____
Check /Receipt No.: _____	IX
Withdrawal Date: _____ / _____ / _____	Control No.: _____

