

Early Learning Preschool Center

Registration Form

Name of child: _____ Date of Birth: _____

Home Address: _____
_____ Phone: _____

Mother (or Guardian): _____

Father (or Guardian): _____

If neither parent can be reached in case of emergency, call:

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

Other people authorized to pick up child from center:

Parents Employment: Mother _____ Phone: _____

Father _____ Phone: _____

Days requested: (circle): M T W H F Hours: From _____ to _____

Beginning Date: _____

Does your child have any allergies? If so, describe:

Name of Physician: _____ Phone: _____

Name of Dentist: _____ Phone: _____

In the event my child becomes ill or injured, I authorize emergency medical care, any necessary transportation and give permission to contact the physician named above on my behalf.

Please give any other helpful information about your child such as play or sleep habits, fears, likes or dislikes:

Parent Signature _____

Date: _____