Early Learning Preschool Center

Registration Form

Name of child: _____ Date of Birth:_____

Home Address: _____

Phone number: _____ email address:_____

Languages spoken at home: _____

Mother or Parent #1 :_____

Father or Parent #2: _____

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: _____

Requested enrollment: (circle): M T W H F Hours: From _____ to _____

Requested start 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: _____