

STUDENT ENROLLMENT APPLICATION

➔ IF YOUR REQUESTED ENTRANCE DATE IS IN THE FUTURE YOU MAY NOT BE GUARANTEED PLACEMENT IN THE PROGRAM FOR THIS DATE. IF YOUR CHILD'S NAME IS PLACED ON OUR 'WAIT LIST' YOU ARE SUBJECT TO AVAILABILITY IN THAT PROGRAM AND THE ORDER OF YOUR ENROLLMENT. THE COMPLEXION OF THE CLASSROOMS AND STUDENTS ARE SUBJECT TO CHANGE AT ANY TIME. WE WILL NOTIFY YOU WITH THE AVAILABILITY FOR YOUR REQUESTED ENTRANCE DATE. ⬅

<input checked="" type="checkbox"/> KIDS R KIDS DOCUMENTATION	ENTERED IN SCHOOL LEADER _____	<input type="checkbox"/> 5	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 1/2
MANAGEMENT INITIALS _____		PROJECTED SUITE _____				
DATE _____	ENTERED ON ENROLLMENT BOARD _____	CONTRACT RATE _____				
	ENTERED ON CALENDAR _____	PROMOTIONAL OFFER _____				

REQUESTED ENTRANCE DATE _____

CHILD'S NAME _____
 PRIMARY ADDRESS _____
 MOTHER/GUARDIAN NAME _____
 ADDRESS (IF DIFFERENT) _____
 EMPLOYER _____
 MOBILE PHONE _____
 EMAIL _____

FATHER/GUARDIAN NAME _____
 ADDRESS (IF DIFFERENT) _____
 EMPLOYER _____
 MOBILE PHONE _____
 EMAIL _____

HOW DID YOU HEAR ABOUT US? INTERNET SITE
 NEWSPAPER REFERRAL PROMOTION MAGAZINE
 AGENCY/BUSINESS OPEN HOUSE (CHECK ALL THAT APPLY)

BIRTH DATE _____
 CITY/ZIP _____
 HOME PHONE _____
 CITY/ZIP _____
 BUSINESS PHONE _____
CIRCLE FIRST-TO-BE CONTACTED NUMBER

HOME PHONE _____
 CITY/ZIP _____
 BUSINESS PHONE _____
CIRCLE FIRST-TO-BE CONTACTED NUMBER

- * ALLERGIES MUST BE SUPPORTED AS SUCH IN WRITING BY THE CHILD'S PHYSICIAN
- CHILD'S KNOWN FOOD 'ALLERGIES' _____
- * OTHER KNOWN 'ALLERGIES' _____
- * FOOD MAY NOT BE PROVIDED BY OUTSIDE SOURCES - KIDS R KIDS WILL STRIVE TO ACCOMMODATE REQUESTS FOR DIETARY PREFERENCES & RELIGION
- SPECIAL DIETARY REQUESTS _____
- * HAS YOUR CHILD BEEN IN A 'CHILD CARE' PROGRAM BEFORE? _____
- * PLEASE NOTE ACCOMMODATIONS NECESSARY TO MEET YOUR CHILD'S NEEDS _____
- * CHILD'S PRE-EXISTING ILLNESSES AND/OR BEHAVIOR DIAGNOSIS _____
- * CURRENT MEDICATION FOR ILLNESSES AND/OR BEHAVIOR SYMPTOMS _____

CHILD'S PHYSICIAN NAME _____
 CITY OF OFFICE _____
 INSURANCE CARRIER _____
 HOSPITAL PREFERENCE _____ ANY _____

DOCTOR'S GROUP NAME _____
 OFFICE PHONE _____
 POLICY # _____
 HOSPITAL PHONE _____

EMERGENCY CONTACTS:

NAME _____	RELATIONSHIP _____
PHONE # 1 _____	PHONE # 2 _____
NAME _____	RELATIONSHIP _____
PHONE # 1 _____	PHONE # 2 _____

AUTHORIZED PEOPLE FOR PICK UP:

1. _____
2. _____
3. _____
4. _____
5. _____

PLEASE REVIEW APPLICATION TO ENSURE ALL LINES HAVE ACCURATE INFORMATION LISTED OR MARKED N/A.
 A 'REGISTRATION FEE' IS REQUIRED WHEN SUBMITTING APPLICATION. THIS FEE IS NON-REFUNDABLE.

PARENT/GUARDIAN SIGNATURE _____

APPLICATION DATE _____