Enrollment Information Form

Your Child's Full Name _____ Sex ☐ M ☐ F

Name Child is Called _____ Birth Date _____

Race ☐ White, Non-Hispanic ☐ Black, Non-Hispanic ☐ Hispanic

☐ Asian/Pacific Islander ☐ American Indian ☐ Multiracial

Physical Address _____ Home Ph. _____

Mailing Address *(if different)* _____

Mother's Name	
Address *(if different)*	
Home Phone	
Employer	
Occupation	
Work Phone	
Cell Phone	
Cell Phone Provider	
Email address	

Father's Name	
Address *(if different)*	
Home Phone	
Employer	
Occupation	
Work Phone	
Cell Phone	
Cell Phone Provider	
Email address	

Emergency Contacts if parent can't be reached:

Name _____ Name _____

Phone _____ Phone _____

Persons Approved to Pick Up Your Child (other than parents) _____

Child's Physician and phone number _____

Does your child have any allergies or physical/social limitations that we should be aware of? _____

List brothers and sisters of your child, if any, and their ages _____

Are there others living in the home? ☐ Yes ☐ No

Are there pets? What kind and name? ☐ Yes ☐ No _____

Does the family belong to a church? ☐ Yes ☐ No If yes, where? _____

Has the child attended preschool? ☐ Yes ☐ No If yes, where? _____

Parent's Signature _____ Date _____

Class in which you are registering your child:

VPK ☐ 5-day

Age of child as of September 1st of this year *(must be 2 by September 1st of this year)* _____

Date received _____ Check #/Cash _____ Amt $_____ Confirmation Date _____

☐ Copy of Birth Certificate

☐ Copy of Authorization for EMT

☐ Copy of Blue & Yellow Health Forms

☐ Photo Release

☐ $100 Registration Fee

☐ $150 Supply Fee

New Hope Early Learning, 120 N. Knights Avenue, Brandon FL 33510

813-689-9482 wendy@brandonchurch.com

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

If my child, _____ should become ill or injured at New Hope Early Learning, I understand that the facility will: (1) Contact me immediately and (2) contact the person(s) I have designated if I cannot be reached. Should the facility be unable to reach me and/or the person(s) designated, they are authorized to contact my child's physician and/or arrange for immediate emergency medical treatment.

The physician and/or medical facility are authorized to administer emergency medical treatment necessary to ensure the health and safety of my child.

I will accept responsibility for payment of medical services rendered.

Signature: _____ Relationship:_____
Date: _____

Medical Alert Information (i.e. allergies, medical and/or handicapping conditions):

_____
_____
_____

Preferred Physician_____ Preferred Hospital: _____
Address of Physician:_____ Phone:_____

MEDIA RELEASE

I, the undersigned, do hereby grant permission to New Hope Early Learning to use the image of my child. Such use includes the display, distribution, publication, transmission, or otherwise use of photography, images, and/or video take of my child for use in materials that include, but may not be limited to, printed materials such as brochures and newsletters, videos, and digital images such as those on the New Hope website.

☐ **Deny** permission to use my child's image at all. Please be advised that some photos and videos are taken as part of craft projects.

_____ Date: _____
Parent/Guardian Signature

VERIFICATION OF PARENT'S RECELIVING REQUIRED DOCUMENTS

_____ KNOW YOUR CHILD'S DAY CARE CENTER

_____ BEHAVIORAL GUILDELINES AND DISCIPLINARY PRACTICES

_____ INFLUENZA VIRUS, THE FLU, A GUIDE TO PARENTS

_____ ALTERNATE NUTRITION AGREEMENT

I agree to provide _____ with a morning snack to meet my child's nutritional and dietary needs.