

**ENROLLMENT INFORMATION
YOUNG AGES SCHOOL**

Facility: Young Ages School		Director: Alisa Gardner	Date of Admission:
Child's First Name: Middle Last		Date of Birth:	
Child's Address:		City	Zip Code
Child's Age:	Male: Female:	Child lives with: Both Mother Father Split	
Father's Name:	Occupation& Place of Employment	Work Phone: Cell Phone: E-mail:	
Mother's Name:	Occupation& Place of Employment	Work Phone: Cell Phone: E-mail:	
Name to call in emergency (if parents cannot be reached)			
Name:	Relationship:	Phone #: Address:	
I hereby authorize this facility to allow my child to leave the facility ONLY with the following persons: (other than parents and grandparents)			
Name: _____		Phone #: _____	
Name: _____		Phone #: _____	

Parent's Church Preference and/or Membership: _____

Names and ages of brothers and sisters:

Name: _____ Age: _____ Name: _____ Age: _____
Name: _____ Age: _____ Name: _____ Age: _____

Class Desired (Indicate 1st and 2nd preference)*	Transitional Kindergarten: 5 year old Monday - Friday (9:00-1:45) _____
3 year old Tuesday and Thursday (9:00-12:00) _____ or Monday, Wednesday and Friday (9:00-12:00) _____	Before or after school care: You must enroll with Children Come First Day Care Contact: Ashli Fischer 687-2231 Days _____ Hours _____
4 year old Monday, Wednesday and Friday (9:00-12:00) _____ or Monday through Friday (9:00-12:00) _____	
* Classes are filled in order that completed Enrollment Form and Non-Refundable Registration Fee are received.	

List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries during the past 12 months, any medication prescribed for long-term continuous use, and any other information which staff should be aware of:

ALLERGIES:

OTHER:

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take my child to:		
Name of Physician:	Address:	Phone #:
Name of Hospital:	Address:	Phone #:

I give consent for this facility to secure any and all necessary emergency medical care for my child.

Signature of Parent or Legal Guardian: _____

Registration Paid is NON-REFUNDABLE- \$ _____ Date: _____