CHILD ENROLLMENT DATA

WELCOME TO OUR CENTER

Enrollment Date ___________________________

CHILD'S INFORMATION

Child's full name ____Age________

Child's birthdate _________________

Child's Address __________________________________ Telephone _________

THIS STATEMENT IS FOR SCHOOL AGE CHILDREN ONLY:

MY CHILD ATTENDS_______________________ AND SHOT RECORD IS LOCATED AT HIS/HER SCHOOL.

Parent Signature___________________________Date________________

Child's Special
Needs/Likes/Dislikes____

FAMILY INFORMATION

Mother's Name____

Address___________________________________Zip Code_________________

Telephone #______________Cell #_______________Work #_______________

Employer________________________Address____________________________

Father's Name ____

Address____________________________________Zip Code________________

Telephone #______________Cell #________________Work #________________

Employer___________________________Address_________________________

Other Household Members ____

MEDICAL & HEALTH INFO

Child's Physician________________________Telephone # __________________

Physician's Address_______________________State/Zip____________________

My Child is Allergic to____

My Child is Physically Restricted From___________________________________

____

MAGIC KINGDOM HAS PERMISSION TO SEEK EMERGENCY MEDICAL TREATMENT FOR MY CHILD. I WILL BE RESPONSIBLE FOR ANY AND ALL CHARGES ABOVE INSURANCE BENEFITS THAT ARE INCLUDED AS A RESTULT OF THE MEDICAL TREATMENT FOR MY CHILD.

PARENT/GUARDIAN SIGNATURE______________________DATE________

PARENTS WILL BE NOTIFIED AS SOON AS POSSIBLE IN THE CASE OF ANY EMERGENCY.

EMERGENCY CONTACTS **OTHER THAN MY PARENTS, MY CHILD MAY BE RELEASED TO THE FOLLOWING PERSONS** (PERSON(S) WILL HAVE TO PRESENT IDENTIFICATION)

1. ____
NAME TELEPHONE # RELATIONSHIP

2. ____
NAME TELEPHONE # RELATIONSHIP

3. ____
NAME TELEPHONE # RELATIONSHIP

PARENT SIGNATURE_____________________________DATE______________

MAGIC KINGDOM LEARNING CENTER WILL MAKE EVERY EFFORT TO KEEP EACH FAMILY INFORMED OF ALL ACTIVITIES. THEREFORE, PERIODICALLY WE WILL HAVE "PARENT MEETINGS." WE WILL MAKE SURE THAT YOU ARE INFORMED AT LEAST A WEEK IN ADVANCE. THANK YOU FOR TRUSTING US WITH YOUR MOST PRECIOUS GIFT.

ANNUAL CHILD HEALTH HISTORY/ASSESSMENT

Child's Name _________________________ Date of Birth _____________

Please check all that apply and list any health information needed to care for your child.

Any known allergies/sensitivities to: No Yes If yes, please list

- Medications _________________________
- Foods _________________________
- Others _________________________

Any chronic illness No Yes
Or medical conditions:
Asthma
Diabetes
Seizures
Heart Problems
Other _______________________

Any Disabilities: No Yes
Hearing Impairment
Visual Impairment
Developmental Delay
Physical Impairment
Emotional Problems
Other _________________________

Fees:

The total fee is $____________. Fees are due every week/biweekly payments must be approved.

Payments for child care is due on Friday or Monday morning.

Form of payment accepted: Cash/Check/Money Order/DHS Certificate