



## CHILD ENROLLMENT FORM

The following information is required by the Mississippi State Department of Health, Child Care Licensure Branch. This information is necessary to help “protect and promote the health and safety” of your child. Please provide a response to every item on this form. If the item is not applicable, please answer “N/A”.

Child’s Full Name \_\_\_\_\_ Nickname \_\_\_\_\_

Child’s Birthdate: \_\_\_\_\_ Male or Female \_\_\_\_\_

Mother’s Full Name: \_\_\_\_\_

Mother’s Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mother’s Home Phone: \_\_\_\_\_ Pager or Cell # \_\_\_\_\_

SSN: \_\_\_\_\_ DOB \_\_\_\_\_

Email Address: \_\_\_\_\_

Mother’s Employer: \_\_\_\_\_

Employer’s Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Mother’s Occupation: \_\_\_\_\_

Work Phone: \_\_\_\_\_ ext. \_\_\_\_\_

Father’s Full Name: \_\_\_\_\_

Father’s Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Father’s Home Phone: \_\_\_\_\_ Pager or Cell # \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Father’s Employer \_\_\_\_\_

Employer’s Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Father’s Occupation: \_\_\_\_\_

Work Phone: \_\_\_\_\_ ext. \_\_\_\_\_

Childcare Rate: \$ \_\_\_\_\_ Late Fees: \$20

Parent Signature: \_\_\_\_\_

Director Signature: \_\_\_\_\_

## Emergency Contacts

**Primary** Emergency Contact (other than parents/guardian):

Name \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Emergency Contact Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Relationship to Child: \_\_\_\_\_

**Secondary** Emergency Contact (other than parents/guardian):

Name \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_  
Second Emergency contact address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Relationship to Child \_\_\_\_\_

**Person(s) authorized to pick up my child (Besides parents/guardians or emergency contacts):**

#1 \_\_\_\_\_ #4 \_\_\_\_\_  
#2 \_\_\_\_\_ #5 \_\_\_\_\_  
#3 \_\_\_\_\_ #6 \_\_\_\_\_

**A Step Above Learning Center will not be responsible for paying for the child's health care.**

1. Child's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
2. Preferred Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_
3. Insurance Company: \_\_\_\_\_ Policy # \_\_\_\_\_
4. Regular Medications: \_\_\_\_\_
5. Blood Type: \_\_\_\_\_ If Known
6. Medicine allergic to: \_\_\_\_\_
7. Food Allergies: \_\_\_\_\_
8. Any other Allergies: \_\_\_\_\_
9. Any special health conditions: \_\_\_\_\_
10. Any Special Needs: \_\_\_\_\_

**Accidental Medical Responsibility:** If your child is involved in an accident and requires medical attention, you will be financially responsible for any cost. This is the same policy as if the accident had occurred at the public schools, church or at home. The center carries liability insurance but is different from and should NOT be confused with Accidental insurance.

Parent/Guardian Signature: \_\_\_\_\_ / \_\_\_\_\_ Date \_\_\_\_\_

**Hours of Care Needed:**

Monday     \_\_ to \_\_  
Tuesday    \_\_ to \_\_  
Wednesday \_\_ to \_\_  
Thursday   \_\_ to \_\_  
Friday      \_\_ to \_\_

**Meals Needed:**

Breakfast    Yes or No  
Lunch        Yes or No  
Snack 1      Yes or No  
Snack 2      Yes or No

## Miscellaneous

Initials

I have received a copy of the Parent Handbook and I have read both of these and understand the contents of each.

Yes \_\_\_ No \_\_\_ \_\_\_\_\_

Photography Authorization – I give my permission for the child listed on this application to be photographed or videotaped while in attendance at this center during center activities.

Yes \_\_\_ No \_\_\_ \_\_\_\_\_

I give my permission for the child listed on this application to participate in field trips sponsored by this center. I understand that I will need to sign a permission slip for each trip.

Yes \_\_\_ No \_\_\_ \_\_\_\_\_

I authorize this center to administer prescription and non-prescription medication as necessary for my child. I understand that medication of all types will only be administered per published instructions, obtained either from the physician or from the original container of medication.

Yes \_\_\_ No \_\_\_ \_\_\_\_\_

I authorize this center to obtain any and all medical treatment to be performed as deemed necessary by licensed medical personnel, including emergency medical personnel, ambulance personnel and hospital doctors and nurses.

Yes \_\_\_ No \_\_\_ \_\_\_\_\_

I give my permission for the child listed on this application to use sunscreen and Off in spring and summer months.

Yes \_\_\_ No \_\_\_ \_\_\_\_\_

### Signatures:

Director/Owner: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

**(I understand that this is a legally binding document, and have read it and understand it)**

**Start Date:** \_\_\_\_\_

# Parent Info and Emergency Contacts

(This form is to be filled out so that the center can contact you in case of an emergency that forces us off site)

**Childs Name:** \_\_\_\_\_

**Mom Name:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Dad Name:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Primary Emergency Contact (other than parents/guardian):**

**Name** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Relationship to Child:** \_\_\_\_\_

**Secondary Emergency Contact (other than parents/guardian):**

**Name** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Relationship to Child:** \_\_\_\_\_

**Please update this form as needed.**

## Change in Schedule

Leave this form blank unless change is needed

(To be filled out only when parent needs to notify center of an unauthorized or abnormal pickup procedure)

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Change in Pick-up time: \_\_\_\_\_

Who can pick child up: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Phone: \_\_\_\_\_

Time of Pick-up: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\*\*\*Please notify person picking up child to bring photo

