



# Little Lambs Play and Learn

CHILD CARE CENTER AND PRESCHOOL  
Learning through play, growing with God

Enrollment Application 2010/2011

Date of Application \_\_\_\_\_

Date of Enrollment \_\_\_\_\_

## Student

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

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

Nickname: \_\_\_\_\_ Sex \_\_\_\_\_

\_\_\_\_\_

Date of birth: \_\_\_\_\_

City

State

Zip

## Responsible Party

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_

\_\_\_\_\_

Cell Phone: \_\_\_\_\_

City

State

Zip

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

## Student's Program

### CHECK ONE

Infant 6 weeks to 18 months	<input type="checkbox"/>
Toddler 18 months to 3 years	<input type="checkbox"/>
Preschool 3 to 5 years	<input type="checkbox"/>
Kindergarten 5 to 6 years	<input type="checkbox"/>
School Age 6 years +	<input type="checkbox"/>

### CHECK ONE

	M	T	W	TH	F
All Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afternoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### OTHER DAYS Childcare is needed

### CHRISTMAS BREAK CAMP

	M	T	W	TH	F
Week 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Week 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drop off:				Pick up:	

### EXTENDED CARE (if needed)

Morning Extended	Drop Off Time	
Afternoon Extended	Pick Up Time	
Total # of Hours	7 am to 9 am 3 pm to 6 pm	

### SUMMER PROGRAM

	M	T	W	TH	F
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drop off:				Pick up:	

## Emergency Contact (other than parent or guardian)

Name	Address	Relationship	Phone Number

## Agreement

In case of emergency or serious illness, when parents cannot be reached immediately, I hereby authorize the provider to obtain emergency medical care and/or provide emergency medical transportation.

Parent/Legal Guardian Signature \_\_\_\_\_

I give Little Lambs permission to take photos of my child while attending. Further, I give permission to utilize these photos in their marketing efforts including brochures, websites, newsletters, or password-protected photo sharing programs.

Parent/Legal Guardian Signature \_\_\_\_\_

I have read the parent handbook. I understand and agree to abide by all policies as indicated in the handbook.

Parent/Legal Guardian Signature \_\_\_\_\_

I understand the payment policy that tuition is due the 1st of the month for that month.

Responsible Payer Signature \_\_\_\_\_

**Mother or Guardian**

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
\_\_\_\_\_  
City State Zip Work Phone: \_\_\_\_\_  
Place of Employment: \_\_\_\_\_ Employer Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Email: \_\_\_\_\_  
City State Zip

**Father or Guardian**

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
\_\_\_\_\_  
City State Zip Work Phone: \_\_\_\_\_  
Place of Employment: \_\_\_\_\_ Employer Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Email: \_\_\_\_\_  
City State Zip

**Other Persons Authorized to Pick-up Child**

Name	Relationship	Phone Number

**Other people living in the home**

Name	Relationship	Age

**Out of State Contact**

Name	Address	Phone Number	Relationship

**Doctor**

Name: \_\_\_\_\_ Doctor Phone: \_\_\_\_\_  
Student's Allergies/Food Sensitivities: \_\_\_\_\_  
Student's Medications: \_\_\_\_\_



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## Annual Child Health History/Assessment

### Child Information

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

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

\_\_\_\_\_ Height: \_\_\_\_\_  
City State Zip

Parent(s)/Guardians: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Phone: \_\_\_\_\_

### Health Assessment

#### Any Known Allergies or Food Sensitivities

	No	Yes	If yes, please list
Medications			
Foods			
Other			

#### Any Chronic Illnesses or Medical Conditions

	No	Yes
Asthma		
Diabetes		
Seizures		
Heart Problems		
Other:		

#### Any Disabilities

	No	Yes
Hearing Impairment		
Visual Impairment		
Developmental Delays		
Emotional Problems		
Physical Impairment		
Other:		

Additional health information:

Medications your child takes:

Any instructions for your child's daily care:

### Doctor

Name of child's doctor: \_\_\_\_\_ Name of child's dentist: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Last Exam: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Last Exam: \_\_\_\_\_

Instructions for child's emergency care: \_\_\_\_\_

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