



Enrollment Application

Pre-Enrollment Visit: _____

Enrollment Date: _____

Please provide us with the following information to enable us to care for your child.

Family Last Name: _____

(Circle One) Married Single Divorced Widowed Separated

STUDENT INFORMATION

Child's first Name _____ Middle Name _____ Last Name _____

Preferred Name _____ Child's Social Security Number _____ Date of Birth _____

Transportation: Yes No **Swimming:** Yes No **Sex:** Female Male **Field Trip:** Yes No **Drop in:** Yes No

Photography: I do or do not give permission for my child to be photographed or videotaped while at Bright Ideas.

Meals received: Breakfast Lunch PM Snack **Normal days of care:** Mon Tues Wed Thurs Fri

Normal Hours of Care Summer: From _____ to _____ **Normal hours of care for School Year:** from _____ to _____ and from _____ to _____.

Special Needs: Please list and discuss with Center Director any existing illness, allergies, injury, hospitalization, medication prescribed for long-term or continuous use during the past 12 months: _____

MEDICAL INFORMATION

Doctor: _____ Hospital Preference _____

Address: _____ Primary Health Insurance Carrier: _____

Phone #: _____ Policy #: _____

Please provide a copy of Immunization Certificate to Center Director and submit updated copies as needed.

PRIMARY CONTACT

Relationship: Mother Father Neighbor Friend Other (Specify) _____

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____

City, State, Zip: _____

Home Phone: (____) _____

Work Phone: (____) _____

Driver's License #: _____

Email address: _____

Contact Person's date of birth: _____ - _____ - _____

Employer: _____

Employer address: _____

City, State, Zip: _____

Work Hours: _____

Permission to pick up child? yes no

Responsible for payment? yes no

Contact in an Emergency? yes no

Lives with child? yes no

ADDITIONAL EMERGENCY CONTACT

Relationship: Mother Father Neighbor Friend Other (Specify) _____

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____

City, State, Zip: _____

Home Phone: (____) _____

Work Phone: (____) _____

Driver's License #: _____

Email address: _____

Contact Person's date of birth: _____ - _____ - _____

Employer: _____

Employer address: _____

City, State, Zip: _____

Work Hours: _____

Permission to pick up child? yes no

Responsible for payment? yes no

Contact in an Emergency? yes no

Lives with child? yes no

ADDITIONAL EMERGENCY CONTACT

Relationship: Mother Father Neighbor Friend Other (Specify) _____

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____

City, State, Zip: _____

Home Phone: (____) _____

Work Phone: (____) _____

Driver's License #: _____

Email address: _____

Contact Person's date of birth: _____ - _____ - _____

Employer: _____

Employer address: _____

City, State, Zip: _____

Work Hours: _____

Permission to pick up child? yes no

Responsible for payment? yes no

Contact in an Emergency? yes no

Lives with child? yes no

Parent Signature _____