Learn By Playing - Enrollment Form

Child's Information

Child's Full Name: ____________________ Date of Birth: ____________________

Address: ____________________ Home Phone: ____________________

City: ____________________ PC / Zip Code: ____________________

Teudat Zehut: Nickname:

Mother's Information

Mother's Full Name: ____________________ Home Phone: ____________________

Address: ____________________ Work Phone: ____________________

City: ____________________ PC / Zip Code: ____________________

Occupation: ____________________ Nick Name: ____________________

Name of Employer: ____________________ Cell Phone: ____________________

Business Address: ____________________ Teudat Zehut # ____________________

Work Hours:

Father's Information

Father's Full Name: ____________________ Home Phone: ____________________

Address: ____________________ Work Phone: ____________________

City: ____________________ PC / Zip Code: ____________________

Occupation: ____________________ Nick Name: ____________________

Name of Employer: ____________________ Cell Phone: ____________________

Business Address: ____________________ Teudat Zehut # ____________________

Work Hours:

Guardian's Information

Parent / Guardian with legal custody: ____________________

Parents are: Married [ ] Living Together [ ] Divorced [ ] Separated [ ] Widowed [ ] Single [ ]

Other Household Members: ____________________

Names: Ages: Relationships:

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Child Pick-Up Information

Please list below the people who have *Permission* to pick up your child.

***Note: Anyone picking up your child must have picture ID.**

Name: ____________ **Phone:** ____________ **Relationship:** ____________

Name: ____________ **Phone:** ____________ **Relationship:** ____________

Name: **Phone:** **Relationship:**

Primary Emergency Contact (other than parents or guardian)

Name: ____________

Home Phone: ____________ **Work Phone:** ____________

Relationship to Child: ____________

Address:

Secondary Emergency Contact (other than parents or guardian)

Name: ____________

Home Phone: ____________ **Work Phone:** ____________

Relationship to Child: ____________

Address: ____________

Any Special Instructions on how to reach parents: ____________

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Emergency Information

1. Child's Physician: ____________ Phone: ____________
2. Insurance Company: ____________ Policy #: ____________
3. Medicine allergic to: ____________
4. Immunization Record: ____________ 5. Food Allergies: ____________

4a. Date of Last Immunization: ____________ 6. Any other Allergies: ____________

7. Any special health conditions: ____________

My Child has had the following:

	CHECK BOX		CHECK BOX
Measles:	[ ]	Headaches:	[ ]
German Measles:	[ ]	Earaches:	[ ]
Chicken Pox:	[ ]	Sore Throat:	[ ]
Mumps:	[ ]	Stomach Aches:	[ ]
Whopping Cough:	[ ]	Flu / Colds:	[ ]
Other:		Other:	

Immunization Records

DPT Date 1:	____________	DPT Date 2:	____________
Polio Date 1:	____________	DPT Date 4:	____________
Polio Date 1:	____________	Polio Date 2:	____________
Polio Date 3:	____________	Polio Date 4:	____________
MMR:	____________	TB:	____________
Measles:	____________	HIV:	____________
Mumps:	____________	HIB:	____________
Rubella:			

Other Important Information / Provisions

Do you have any outstanding concerns? Please explain. ____________

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