

Office Use Only
Schedule Summary
 Application Date: _____
 Program (Time): _____
 Class: _____
 Requested Start: _____

Parks' Place

Day Care and Learning Center

Office Use Only
Financial Summary
 Amount Due: _____
 Registration: _____
 Start Date: _____
 Deposit: _____
 TTL prior to start: _____
 Amount Paid: _____
 Balance Due: _____

Express Enrollment Form

Note: This form is a "place holder" for the waiting list or a "preferred reservation" to start.

PART I - Child's Information

Gender: Male Female

Last Name: _____ First Name: _____

Any Parent Restrictions? Yes No Comments: _____

Field Trip Restrictions? Yes No Comments: _____

Photo Restrictions? Yes No Comments: _____

Other Restrictions? Yes No

Please give details on other restrictions: _____

PART II - Parent #1/Guardian #1 Information

(Check): Mr. Mrs. Ms. Miss Dr. Other: _____

Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____

Place of Employment: _____

Work Address: _____ City: _____ State: _____ Zip: _____

E-mail (print clearly): _____

How did you hear about Parks' Place? _____

PART III - Parent #2/Guardian #2 Information

(Check): Mr. Mrs. Ms. Miss Dr. Other: _____

Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____

Place of Employment: _____

Work Address: _____ City: _____ State: _____ Zip: _____

E-mail (print clearly): _____

How did you hear about Parks' Place? _____

SS#: _____

PART IV – Emergency Contacts and Authorized Pick-ups

Secret password for "Unusual Pick-up": _____

Authorized Pick-up Person #1

Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____

Place of Employment: _____

Work Address: _____ City: _____ State: _____ Zip: _____

E-mail (print clearly): _____

Authorized Pick-up Person #2

Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____

Place of Employment: _____

Work Address: _____ City: _____ State: _____ Zip: _____

E-mail (print clearly): _____



Part V – Parent Permission for Emergency Medical Treatment

In an event of a medical emergency, do you wish us to call your family physician? Yes No If yes:

Name of Physician: _____ Phone: _____

Name of Medical Center: _____

Address: _____ City: _____ State: _____ Zip: _____

Please complete the below authorization:

I/we _____ do hereby state that I am/we are parent(s)/
Parent(s)/Guardian(s) Name

legal guardian(s) of _____, a minor, age _____ born on _____,
Child's Name Child's Age Child's DOB

who resides with me/us at _____ . I/We authorize, for emergency
Home Address

purposes only, a designated employee of the center to transport the above minor by ambulance and consent to any necessary examination, anesthetic, medical diagnosis, surgery, or treatment, by a hospital or surgeon licensed to practice medicine in the State of _____ .
State

Last known allergies (food, etc.): _____

Parent(s)/Guardian(s) Signature

Date

Center Director (Witness)

Date