

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

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

**Eyes of the World  
Discovery Center  
2015-2016**

Enrollment Form

Which program will your child be attending?

\_\_\_ Preschool

\_\_\_ Pre-K

Child's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Town: \_\_\_\_\_ State: \_\_\_\_\_

Parent #1: \_\_\_\_\_ Address: \_\_\_\_\_

Parent #2: \_\_\_\_\_ Address: \_\_\_\_\_

Phone numbers where parents can be reached during the day:

Parent #1 (H): \_\_\_\_\_ Parent #1 (W): \_\_\_\_\_

Parent #1 (C)

Parent #2 (H): \_\_\_\_\_ Parent #2 (W): \_\_\_\_\_

Parent #1 (C)

E-mail address

Other method of contact while your child is in our care (i.e. Cell Phone or Pager):

Parent #1's place of employment & address:

Parent #2's place of employment & address:

Persons to contact in case of emergency \*\*\*OTHER THAN PARENT OR GUARDIAN\*\* Please be sure to include a non-family member contact (neighbor, friend etc.)

Contact #1: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

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

Contact #2: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

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

Medical Information:

Doctor's Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

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

Town/State: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

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

Town/State: \_\_\_\_\_

**If, in the event of an emergency and your doctor cannot be reached, we will use Kittery Family Practice.**

Which hospital do you use? \_\_\_\_\_

Any allergies, disabilities, or other medical conditions? If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

Please list any special needs (or any other information) that you would like to share with our staff to help them provide proper care for your child.

\_\_\_\_\_  
\_\_\_\_\_

**Release Information:**

Please list anyone who has your permission, including your name and your spouses/partners name, to pick up your child from this program. Anyone who is not listed will not be permitted to remove your child from the program. A picture ID is required at the time of pick up.

\_\_\_\_\_  
\_\_\_\_\_

Please list anyone that does not have your permission to pick up your child from this program. Please include their relationship to your child.

\_\_\_\_\_  
\_\_\_\_\_

Your signature at the bottom of this page acts as your contract and agreement to the payment contract guidelines outlined in the parent packet. This guarantees payment for the services rendered. Signing this form enables your child to have a reserved sp

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

\_\_\_\_\_  
Date

**YOUR CHILD WILL NOT BE ENROLLED UNTIL ALL AREAS ARE FILLED OUT COMPLETELY. THIS INCLUDES ADDRESSES AND PHONE NUMBERS OF DOCTOR, DENTIST AND ALL CONTACTS.**

