

Date of Entry _____

Registration Fee _____

Classroom _____

Tuition _____



A READINESS LEARNING ACADEMY CHILD ENROLLMENT FORM

Child's Full Name: _____ Preferred Name: _____

Date of Birth _____ Sex _____ First Date of Attendance _____

Address _____ City & State _____ Zip Code _____

Mother's Name _____ Father's Name _____

E-mail Address _____ E-mail Address _____

Custodial Parent (Circle One): Mother Father Joint

Home Phone: _____ Cell: _____ Home Phone: _____ Cell: _____

Employer: _____ Employer: _____

Work Phone: _____ Work Phone: _____

Persons Authorize To Remove Child (Identification Required)

1. _____
Name Relationship Home/Cell Phone Work Phone

Address

2. _____
Name Relationship Home/Cell Phone Work Phone

Address

All parents must receive a copy of "The Flu", a guide for parents, CF/PI 175-70, "KNOW YOUR CHILD'S DAY CARE FACILITY BROCHURE/FDCH BROCHURE", and parents are notified in writing of the "DISCIPLINARY PRACTICES" used by the Academy. The parent's or legal guardian's signature certifies receipt of "The Flu", the child care facility brochure/fdch brochure, discipline policies, and agreement of the alternate nutrition plan.

Signature of Parent or Legal Guardian

Date

Alternate Nutrition Plan Agreement

I understand and approve the use of the Alternate Nutrition Plan. I agree to provide the following meals and/or snacks to meet my child's nutritional and dietary needs.

Indicate Special Dietary Requirements: _____

(Mark P for Parent Provides, or A for Academy Provides)

 Breakfast A.M. Snack Lunch P.M. Snack Formula

Medical Alert Information (i.e., allergies, medical and/or special needs conditions): _____

Preferred Physician: _____

Address: _____ Phone: _____

Preferred Hospital: _____

Preferred Dentist: _____

Address: _____ Phone: _____

Emergency Contacts (Other than Parents)

1. _____
Name Relationship Home/Cell Phone Work Phone

Address

2. _____
Name Relationship Home/Cell Phone Work Phone

Address

Authorization for Emergency Medical Treatment

If my child, _____, should become ill or injured at the Academy,
Child's Full Name

I understand the Academy will (1) contact me immediately and (2) contact the person(s) I have designated; they are authorized to contact my child's physician and/or arrange for immediate medical treatment.

The physician and/or medical facility are authorized to administer emergency medical treatment necessary to ensure the health and safety of my child.

I will accept responsibility for payment of medical services rendered.

Signature

Relationship

Date