



3700 S. US Hwy 27 - Clermont, FL 34711

352/536-9268 (phone)

352/536-9273 (fax)

daycare@celebrationofpraise.net

Date of Application: \_\_\_\_\_

Date of Enrollment: \_\_\_\_\_

## ENROLLMENT APPLICATION

**CHILD'S NAME** \_\_\_\_\_

Nickname \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender: M/F

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Which of the following best describes your child's living Status?

- lives with BOTH MOTHER & FATHER
- lives ONLY with MOTHER
- lives ONLY with FATHER
- lives with GRANDPARENTS
- OTHER \_\_\_\_\_

Does child have any brothers/sisters? If so,

Name \_\_\_\_\_ Age \_\_\_\_\_  
 \_\_\_\_\_ Age \_\_\_\_\_  
 \_\_\_\_\_ Age \_\_\_\_\_

List favorite things (food, toys, movies, etc.)

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

**Father's Name/Guardian** \_\_\_\_\_

(circle one) married divorced single

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Business Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Other \_\_\_\_\_ (\_\_\_\_\_)

Email \_\_\_\_\_

Employed by: \_\_\_\_\_

Occupation: \_\_\_\_\_

**Mother's Name/Guardian** \_\_\_\_\_

(circle one) married divorced single

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Business Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Other \_\_\_\_\_ (\_\_\_\_\_)

Email \_\_\_\_\_

Employed by: \_\_\_\_\_

Occupation: \_\_\_\_\_

**OTHER IMPORTANT CHILD AND/OR FAMILY INFORMATION** \_\_\_\_\_

**PERSON(S) TO NOTIFY IN THE EVENT OF AN EMERGENCY**

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

**PERSON(S) ALLOWED TO PICK UP CHILD (a picture ID will be required to be on file)**

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

# Medical Information

Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

In the event of an emergency, child should be taken to \_\_\_\_\_ Hospital.

Health Concerns \_\_\_\_\_

Known Allergies \_\_\_\_\_

List all current medications: \_\_\_\_\_

Explain any special needs your child has: \_\_\_\_\_

Please check communicable disease(s) that your child has experienced

Chickenpox       Measles       Smallpox       Scarlet fever       Other \_\_\_\_\_

\_\_\_\_\_  
Signature of Father/Guardian

\_\_\_\_\_  
Signature of Mother/Guardian

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

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

## OFFICE USE ONLY

PART or FULL      What days M T W TH F

How many days a week \_\_\_\_\_ Hours \_\_\_\_\_

Weekly amount \_\_\_\_\_ Discounts CM S CCC

Drop off time \_\_\_\_\_ Pick up time \_\_\_\_\_

Teacher \_\_\_\_\_ Group \_\_\_\_\_

Curriculum fee \$75.00 Date Paid \_\_\_/\_\_\_/\_\_\_

Registration received \_\_\_/\_\_\_/\_\_\_

Start Date \_\_\_/\_\_\_/\_\_\_ W/D \_\_\_/\_\_\_/\_\_\_

## CCC PROFILE

Class Rate	CCC	P.F.	Total

**Office  
Use  
Only**

Application	<input type="checkbox"/>
Emergency Med	<input type="checkbox"/>
Financial Agmt	<input type="checkbox"/>
Immunization Record	<input type="checkbox"/>
Physical	<input type="checkbox"/>