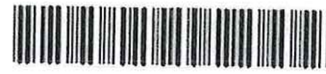

TOP Early Learning Center Enrollment Form

Child's Information

Child's Last Name: ______________________ First Name: ____________________ MI: ____

Child's Nickname: ______________________ Date of Birth: ____________ Age: ____

Child's Social Security #______________________ Gender: Female or Male

Is the child's primary language English? Yes or No If no, what is the primary language? ____________

Race: Caucasian Hispanic Asian African American Native American Pacific Islander Other:________

How did you hear about TOP? ______________________ Kindergarten School: ____________

Parent's Information

Child lives with: Mother Father Both Other: ____________ **Please circle which one applies to you:** Single Married Divorced

Mother/Lawful Guardian	Father/Lawful Guardian
Name:	Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Email:	Email:
Date of Birth: Race:	Date of Birth: Race:
Primary Language:	Primary Language:
Highest Education:	Highest Education:
Mom's SSN:	Dad's SSN:
Employment Information	**Employment Information**
Company:	Company:
Address:	Address:
City, State, Zip:	City, State, Zip:
Work Phone: Work Hrs:	Work Phone: Work Hrs:
Work Days (circle): M T W Th F	Work Days (circle): M T W Th F

Emergency Contacts and Authorized Pickup Information

Authorized person(s) to pick up the child in case of an emergency or illness if the Parent(s) or Lawful Guardian(s) is unavailable or cannot be reached by calling the numbers provided to us on this form. The person bringing or picking up the child must be at least 16 years of age or older.

***Note: Each person on the list will be asked for a photo ID and any person not on the pick up list will not be able to pick up the child. **Note: Please list contacts in the order in which you would like them to be contacted.**

❶ Name:	❷ Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Relationship to Child:	Relationship to Child:

❸Name:______________ Phone #______________ Relationship to Child: ____________

❹Name:______________ Phone #______________ Relationship to Child: ____________

❺Name:______________ Phone #______________ Relationship to Child: ____________

❻Name:______________ Phone #______________ Relationship to Child: ____________

Permission

Please answer the questions below by circling "Yes" or "No"

1)	**I give permission for my child to receive vision, hearing, developmental and psychological screenings provided by qualified professionals.**	**Yes**	**No**
2)	**I give permission for my child to be photographed or video taped for media use.**	**Yes**	**No**
3)	**I understand that my child will be participating in the Child and Adult Care Food Program.**	**Yes**	**No**
4)	**I understand that information regarding my child may be shared via, fax, email, US Postal Service or verbally with other TOP locations, Child Start, Rainbows, Unified School Districts, or other prudent partners.**	**Yes**	**No**

Authorization for Emergency Medical Care for TOP Early Learning Center

Medical Information

Physician's Name: ______________________________ Phone # ______________

Hospital Preference: ______________________________

Health Insurance Information

Health Insurance Carrier: ______________________________ ID # ______________

Do you the parent/guardian qualify for Medicaid? Yes or No If no, what insurance carrier? ______________

Does your child qualify for Military Medical Care? Yes or No If yes, ID # ______________

Is your child allergic to any medications? Yes or No If yes, what? ______________

Is your child allergic to any foods? Yes or No If yes, what? ______________

Date of your child's **MOST RECENT** Tetanus Toxoid Shot or DTP. ______________

This form will be attached to your child's health records. Both forms will be taken to the emergency room.

In order to meet all legal requirements, I hereby authorize the staff of TOP Early Learning Center as representatives of TOP to give consent for any and all necessary emergency medical care for my child, whose name is ______________________ while said child is in said individual's custody beginning on the first day of enrollment and ending when child is no longer enrolled.

Parent Signature: ______________________________ **Today's Date:** ______________

TOP Rep Signature: ______________________________ **Today's Date:** ______________

For Office Only:

Times of Care: ________ to ________ **Days of Care:** M T W Th F (all week) **Meals Served:** B L S