

# R.T.M. KID'S ZONE PRESCHOOL

2010-2011

## Enrollment Form

FOR OFFICE USE ONLY

Date Enrolled \_\_\_\_\_

Class Assigned: \_\_\_\_\_

Date Withdrawn \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

CHILD'S NAME \_\_\_\_\_  
First Middle Last

BIRTHDATE \_\_\_\_\_ SEX \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP CODE \_\_\_\_\_

**CUSTODIAL PARENT (CIRCLE ONE): MOTHER FATHER JOINT OTHER \_\_\_\_\_**

Are there any custody suits or situations that we need to be made aware of?  YES (documentation required)  NO

MOTHER'S NAME \_\_\_\_\_ FATHER'S NAME \_\_\_\_\_

HOME PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

EMPLOYMENT \_\_\_\_\_ EMPLOYMENT \_\_\_\_\_

WORK PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

CELL/PAGER \_\_\_\_\_ CELL/PAGER \_\_\_\_\_

E-MAIL \_\_\_\_\_ E-MAIL \_\_\_\_\_

Special instructions for contacting parents: \_\_\_\_\_

### PERSONS AUTHORIZED TO REMOVE CHILD (OTHER THAN PARENTS)

1. \_\_\_\_\_  
NAME RELATIONSHIP PHONE

2. \_\_\_\_\_  
NAME RELATIONSHIP PHONE

3. \_\_\_\_\_  
NAME RELATIONSHIP PHONE

4. \_\_\_\_\_  
NAME RELATIONSHIP PHONE

5. \_\_\_\_\_  
NAME RELATIONSHIP PHONE

6. \_\_\_\_\_  
NAME RELATIONSHIP PHONE

List any additional information that would be beneficial for the Preschool staff to know about your child:

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

**EMERGENCY INFORMATION**

Child's Physician \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Hospital \_\_\_\_\_

**NOTE: Immunization Record must accompany child.**

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**EMERGENCY CONTACT (OTHER THAN PARENTS)**

1. \_\_\_\_\_  
NAME RELATIONSHIP PHONE

2. \_\_\_\_\_  
NAME RELATIONSHIP PHONE

3. \_\_\_\_\_  
NAME RELATIONSHIP PHONE

**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

If my child, \_\_\_\_\_, should become ill or injured at **R.T.M. KID'S ZONE**

**PRESCHOOL**, I understand that the facility will:

- Contact me immediately and
- Contact the person(s) I have designated if I cannot be reached.

Should the facility be unable to reach me and/or the person(s) 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.

\_\_\_\_\_  
FATHER'S SIGNATURE RELATIONSHIP DATE

\_\_\_\_\_  
MOTHER'S SIGNATURE RELATIONSHIP DATE