# ENROLLMENT FORM
## SCHOOL DISTRICT OF ESCAMBIA COUNTY

Mark an "X" by the address where the child lives.

Child's Name_____
(Last)                (First)            (Middle)           (Alias)

Birth date:_____ Sex:_____ Enrollment Date:_____

Mother's Name:_____ Father's Name: _____

| | Home Address | Phone | Employment Address | Phone |
|---|---|---|---|---|
| Mother | | | | |
| Father | | | | |

Child's Physician:_____

Address:_____ Phone:_____

May the Center call another physician if unable to contact the above?　Yes_____　　No_____

                                               Legal Custody

Person(s) permitted to remove child:　Mother　Yes _____　No_____　　Yes_____　No_____

                                      Father　Yes_____　No_____　　Yes_____　No_____

                                      Guardian　Yes_____　No_____　　Yes_____　No_____

Persons to be contacted in case of illness, accident, or emergency if for some reason the parents or guardians cannot be reached, and authorized to remove the child from the facility  (If none, indicate "None"):

_____
     Name                Address                            Phone           Relationship

_____
     Name                Address                            Phone           Relationship

Other persons authorized by the parents or guardians to take the child(ren) from the facility if different from above (If none, indicate "None"):

_____
     Name                Address                            Phone           Relationship

_____
     Name                Address                            Phone           Relationship

Primary Hours of Care: _____　From_____　To_____

Special Instructions regarding eating habits, toileting, or areas of concern:

_____

_____

_____

_____


_____     _____
         Date                                      Signature of Person Enrolling Child(ren)