TOP Early Learning Center Enrollment Form

Child's Information

Child's Last Name: _____ **First Name:** _____ **MI:** _____

Child's Social Security # _____ **Date of Birth:** _____ **Age:** _____

Gender: Female or Male **Child's Ethnicity:** Hispanic/Latino/Spanish Origin or Non-Hispanic/Non-Latino/Not Spanish Origin

Race: White Asian African American or Black American Indian or Alaska Native Native Hawaiian or Pacific Islander Other: _____

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

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:
Ethnicity: Hispanic/Latino/Spanish Origin or Non-Hispanic/Non-Latino/Not Spanish Origin	Ethnicity: Hispanic/Latino/Spanish Origin or Non-Hispanic/Non-Latino/Not Spanish Origin
Primary Language:	Primary Language:
Highest Education Completed:	Highest Education Completed:
Mom's SSN:	Dad's SSN:

Employment Information	Employment Information
Company:	Company:
Address:	Address:
City, State, Zip:	City, State, Zip:
Work Phone: Work Hours:	Work Phone: Work Hours:
Employed (circle one): Full-Time Part-Time Not Employed	Employed (circle one): Full-Time Part-Time Not Employed

Household Information

of people in household (include everyone): _____ # of children under 18 in household: _____ Annual Income: _____

Emergency Contacts and Authorized Pickup Information

(other than parents/guardians listed above)

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:
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: _____

Permissions

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 and/or partners.**	**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

Please note: TOP Early Learning Center does not provide medical insurance for accidental injuries to students. These plans are available and should be considered in conjunction with any other family medical insurance you may have.

Health Insurance Carrier: _____ ID # _____

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

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? _____

Should any food or beverage be removed from your child's diet due to religion? 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 (all meals)