Registration Fee: $300.00 (non-refundable)
Material Fee: $250.00 (non-refundable)
Application Fee: $50 (non-refundable)
Checks Payable to De Silva Corporation
Check#_____
Date:_____

ENROLLMENT AGREEMENT

Group:_____
Starting Date:_____
Chosen Program (Circle One): Mon to Fri Mon/Wed/Fri Tue/Thur

Full Name of Child _____

Name Child is Called (Nickname)_____

Date of Birth _____Place of Birth _____Sex _____

Chronic Physical Problems/Pertinent Development Information/Special Accommodations Needed

_____

Previous Child Day Care Programs and Schools Attended

_____

If Child Attends this Center and Another School/Program, Give Name of School/Program

_____

Full Name of Father _____Place Employed:_____

Home Address _____

Home Phone _____ Business Phone _____ Cell#_____

Email Address_____

Full Name of Mother _____Place Employed_____

Home Address _____

Home Phone _____ Business Phone _____Cell#_____

Email Address_____

Person(s) or Agency Having Legal Custody of Child_____

EMERGENCY NAMES AND PHONE NUMBERS:

Allergies or Intolerance to Food, Medication, etc., and Action to Take in an Emergency

_____

Physician: Name _____ Phone_____

Two people to contact if Parents cannot be reached:

Name _____ Address _____Phone _____

Name _____ Address _____Phone _____

Parent Signature: _____ Print Name:_____

Person(s)Authorized To Pick Up Child

_____

Person(s)Not Authorized To Pick Up Child

_____

AGREEMENTS

1. The child day care center agrees to notify the parent(s)/guardian(s)whenever the child becomes ill and the parent(s)guardian(s) will arrange to have the child picked up as soon as possible if so requested by the center.

2. The parent(s)/guardian(s) authorize the child day center to obtain immediate medical care if any emergency occurs when the parent(s)guardian(s) cannot to be located immediately.

3. The parent(s)/guardians agree to inform the center within 24hours or next business day after his or her child or any member of the immediate household has developed a reportable communicable disease, as defined by the State Board of Health, except for life threatening diseases which must be reported immediately.

SIGNATURES

_____ _____

Parent(s) or Guardian(s) Date

_____ _____

Administrator of Center Date

Date Child Entered Care:_____ Date Left Care:_____

If there is any objection to seeking emergency medical care, a statement should be obtained from the parent(s)or guardian(s)that states the objection and the reason for the objection.

Identity Verification

Date of Birth:_____ Place of Birth:_____

Birth Certificate/Other Number_____ State Issued_____ Date Issued_____

I certify that above information about the child's age and identity is correct as per the documents provided by the parents to examine.

Name of person viewing documentation_____ Signature_____ Date:_____