



**Enrollment Application**

Child's Name :	Date of Birth:
SSN #	Male <input type="checkbox"/> Female <input type="checkbox"/>

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Mother's Name:	Driver's License number
Home Address	Home Phone:
Employer:	Work Phone
Employer Address	Alternate phone

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Father's Name:	Driver's License number
Home Address	Home Phone:
Employer:	Work Phone
Employer Address	Alternate phone

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**Medical Information**

Practice Name Phone	Physician's Name	
Address	City, State	Zip code
Dentist's Name	Phone	

Known Allergies: YES NO	If yes, please specify:
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Parental Pickup: Father only	Mother Only	Father or mother
Parental Status: Single	Marries	Divorced
Photo Restrictions: YES	NO	
Food Restrictions: YES	NO	if yes, please specify
Other Restrictions:		

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_