|  |
| --- |
| Child Care Center  P.O. Box 6292  Farmington, NM 87499  (505) 325-7578 |

# Enrollment Application

**Entrance Date: Withdrawal Date:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Full Name: |  |  |  | Date: |  |
|  | Last | First | M.I. |  |  |

|  |  |  |
| --- | --- | --- |
| Physical Address: |  |  |
|  | Street Address City State | Zip code |

|  |  |  |  |
| --- | --- | --- | --- |
| Mailing Address |  |  |  |
|  | City | State | ZIP Code |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone: |  | Email |  |

|  |  |
| --- | --- |
| Existing Medical conditions, Medications your child may have: |  |

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| --- |
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| --- | --- |
| My child has the following special needs |  |
|  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Allergies? | YES | NO | If yes, what sort of allergies? |  |

|  |  |  |
| --- | --- | --- |
| Primary hours of care? | **FROM AM/PM** | **TO AM/PM** |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Days of the Week in Care | | |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Sun | Mon | Tues | Wed | Thurs | Fri | Sat | | | |
| Child’s Living Arrangements | |  | | |
| **Guardian #1** |  | |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| First Name: |  | Last Name |  | Relationship to Child? |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Physical Address |  | City |  | State |  | Zip |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Mailing Address |  | City |  | State |  | Zip |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Home Phone |  | Cell Phone |  | Work Phone |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Guardian #2** | |  | |  | |  | |
| First Name: |  | | Last Name | |  | | Relationship to Child? |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Physical Address |  | City |  | State |  | Zip |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Mailing Address |  | City |  | State |  | Zip |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Home Phone |  | Cell Phone |  | Work Phone |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Public School child attends |  | Phone: |  |

Address:

|  |  |  |
| --- | --- | --- |
| **I give permission for my child** |  | **, be transported to or given emergency treatment by a skilled** |

**& qualified staff at:**

|  |  |
| --- | --- |
| **Hospital Provide Name:** | SAN JUAN REGIONAL MEDICAL CENTER |

|  |  |
| --- | --- |
| **Hospital Provider Address** | 801 WEST MAPLE STREET FARMINGTON, NEW MEXICO 87401 |

|  |
| --- |
| **PHONE NUMBER: 505-609-2000** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Guardian Signature:** |  | **Date:** |  |

**Emergency Contacts and Authorize Pick-up ( please ensure that numbers are working numbers)**

Person to contact in case of an emergency when Guardians CANNOT be reached and authorized to pick up child/ren (Emergency Contacts must be in the local area)

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Relationship: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Address |  | Phone (CELL) |  | Work |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Relationship: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Address |  | Phone (CELL) |  | Work |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| From: |  | To: |  | Reason for Leaving: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Relationship: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Address |  | Phone (CELL) |  | Work |  |

|  |
| --- |
| **NOT AUTHORIZED TO PICK UP CHILD:** |
| NAME | RELATIONSHIP |  |
| NAME | RELATIONSHIP |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Guardian Signature |  | Date: |  |
| Site Director Signature |  | Date: |  |