



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: _____