



5130 Northlake Blvd.  
 Palm Beach Gardens, FL 33418  
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OFFICE USE ONLY	
School Year	_____
Class	_____
Starting Date	_____

# REGISTRATION FORM

**Non-refundable registration fee must accompany application**

Child's Name: \_\_\_\_\_ Birthday: \_\_\_\_\_

Age: \_\_\_\_ Years: \_\_\_\_ Months: \_\_\_\_ Sex: Female Male Enrollment Date: \_\_\_\_\_

Child resides with: Both Parents Mother Father Other

Parents marital status: Married Divorced Separated Single

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Work: \_\_\_\_\_ Ext: \_\_\_\_\_ Work: \_\_\_\_\_ Ext: \_\_\_\_\_

Email: \_\_\_\_\_ Email: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Employer's Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Occupation: \_\_\_\_\_

*Please list two or more local emergency contacts who will be authorized to pick up your child from the facility if you cannot be reached.*

Name: \_\_\_\_\_ Cell: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Cell: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Cell: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Cell: \_\_\_\_\_ Relation: \_\_\_\_\_

Child's Physician: \_\_\_\_\_ Hospital Preference: \_\_\_\_\_

Does your child have allergies (Check those that apply): Bee Stings Fire Ants Food Groups Other

How does it manifest itself (Check those that apply): Asthma Hay Fever Hives Other

Any other medical conditions that we should be aware of: \_\_\_\_\_

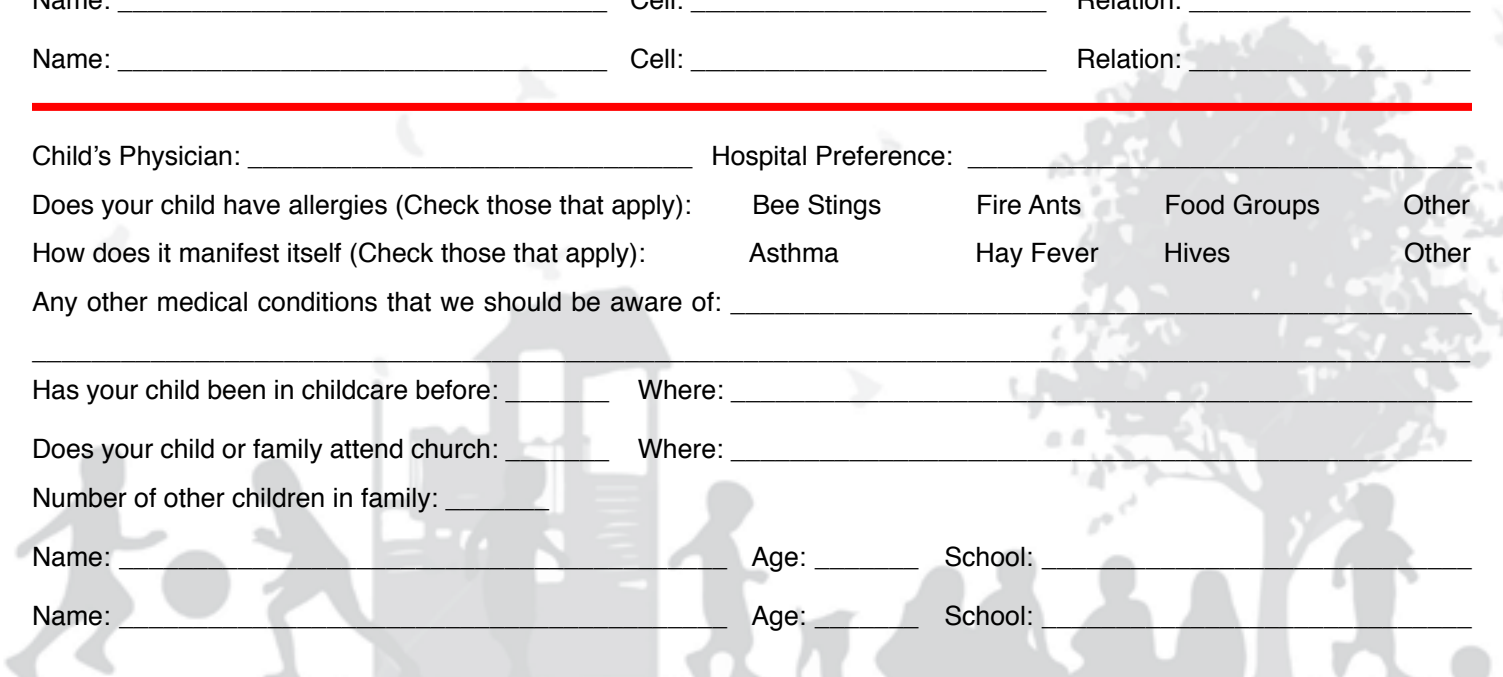
Has your child been in childcare before: \_\_\_\_\_ Where: \_\_\_\_\_

Does your child or family attend church: \_\_\_\_\_ Where: \_\_\_\_\_

Number of other children in family: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ School: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ School: \_\_\_\_\_



**I understand and approve the use of the Alternate Nutrition Plan.**

*I agree to provide the following meals and/or snacks to meet my child's nutritional and dietary needs:*

*(Mark **P** for Parent Provides or **C** for Center Provides)*

**Breakfast**

**AM Snack**

**Lunch**

**PM Snack**

**Formula**

Indicate Special Dietary Requirements: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_

Signature of Parent: \_\_\_\_\_

***I agree to provide the parent with a suggested meal pattern, menu, and to discuss any problems that might develop in the use of the Alternate Nutrition Plan.***

Date: \_\_\_\_\_

Signature of Owner: \_\_\_\_\_

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**I attest that all the above information is correct.**

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_

