FOR OFFICE USE ONLY
Date Received: _____

Group: _____

Priority: _____

Half Time _____Full Time _____
Extended Time_____

LIC # C11MD1693

CHAMPS BRICKELL PRESCHOOL

REGISTRATION FORM

CHILD'S FULL NAME_____

HOME ADDRESS_____

CITY_____ STATE _____ ZIP_____

BIRTH DATE_____BIRTHPLACE_____

CHILD'S SOCIAL SECURITY #: _____ENROLLMENT DATE _____

LANGUAGE(S) SPOKEN AT HOME: _____

HOME PHONE_____ EMERGENCY PHONE_____

EMERGENCY CONTACT PERSON_____

MOTHER/GUARDIAN

FULL NAME _____

ADDRESS _____

CELL PHONE # _____

WORK PLACE _____

WORK PHONE_____ EXT._____

EMAIL _____

FATHER

FULL NAME _____

ADDRESS _____

CELL PHONE # _____

WORK PLACE _____

WORK PHONE_____ EXT._____

EMAIL _____

PLEASE LIST ANY HEALTH PROBLEMS THE SCHOOL SHOULD BE AWARE OF:

PLEASE SUBMIT A COPY OF CHILD'S IMMUNIZATION RECORDS

HEALTH HISTORY FORM – DATE REC'D_____ IMMUNIZATION RECORDS - DATE REC'D_____

REGISTRATION FEE_____ PAID/DATE_____

CHAMPS BRICKELL PRESCHOOL

EMERGENCY INFORMATION

CHILD'S NAME_____

HOME PHONE_____

ADDRESS _____

FATHER

NAME_____ **PHONE**_____

ADDRESS_____

CELL PHONE # _____

WORK_____ **WORK #**_____

EMAIL: _____

MOTHER

NAME_____ **PHONE**_____

ADDRESS_____

CELL PHONE # _____

WORK_____ **WORK #**_____

EMAIL: _____

EMERGENCY CONTACT PERSON (1) _____

PHONE_____ **RELATIONSHIP** _____

EMERGENCY CONTACT PERSON (2) _____

PHONE_____ **RELATIONSHIP** _____

PLEASE INDICATE BELOW THOSE WHO WILL BE PICKING UP YOUR CHILD IN CASE YOU ARE NOT ABLE TO: (THEY MUST BRING AN VALID ID FOR THE CHILD TO BE RELEASED)

NAME	RELATIONSHIP
1._____	_____
2._____	_____
3._____	_____

******IF ANY INFORMATION CHANGES DURING THE SCHOOL YEAR PLEASE LET US KNOW AS SOON AS POSSIBLE. THANK YOU FOR YOUR COOPERATION***