



CHILD ENROLLMENT

Special Learning Center
 1115 Fairgrounds Rd.
 Jefferson City, MO 65109
 (573) 634-3070
 FAX (573) 636-3247

Completed _____
 Updated _____
 Updated _____



CHILD'S NAME:	SEX:	BIRTHDATE:
ADDRESS: Street: _____ City/State/Zip: _____	HOME PHONE NUMBER ()	
IDENTIFYING INFORMATION		
A) MOTHER'S OR GUARDIAN'S NAME:	MOM'S E-MAIL ADDRESS:	
HOME PHONE NUMBER IF DIFFERENT THAN ABOVE:	MOM'S CELL PHONE NUMBER: ()	
HOME ADDRESS IF DIFFERENT THAN ABOVE: Street: _____ City/State/Zip: _____	MOM'S EMPLOYER: _____ BUSINESS TELEPHONE NUMBER: ()	
B) FATHER'S OR GUARDIAN'S NAME:	DAD'S E-MAIL ADDRESS:	
HOME PHONE NUMBER IF DIFFERENT THAN ABOVE:	DAD'S CELL PHONE NUMBER: ()	
HOME ADDRESS IF DIFFERENT THAN ABOVE: Street: _____ City/State/Zip: _____	DAD'S EMPLOYER: _____ BUSINESS TELEPHONE NUMBER: ()	
EMERGENCY CONTACT(S) (OTHER THAN PARENT(S) OR DOCTOR) – (AT LEAST ONE EMERGENCY CONTACT IS REQUIRED)		
NAME OF EMERGENCY CONTACT:	TELEPHONE NUMBER: ()	
ADDRESS: STREET : _____ CITY, STATE, ZIP CODE: _____	RELATIONSHIP	
Optional	NAME OF EMERGENCY CONTACT:	TELEPHONE NUMBER: ()
	ADDRESS: STREET : _____ CITY, STATE, ZIP CODE: _____	RELATIONSHIP
*DAYCARE PROVIDER: _____ Address: _____ Phone: _____ Contact: _____		
PERSON(S) OTHER THAN PARENTS AUTHORIZED TO TAKE CHILD FROM SPECIAL LEARNING CENTER:		
Name: _____	Name: _____	
Name: _____	Name: _____	

Please complete the back.

COMMENTS ON CHILD’S DEVELOPMENT

(Note allergies, medications, health concerns, habits, special/language development, etc.)

AUTHORIZATION FOR EMERGENCY MEDICAL CARE:

I understand that I will be notified at once in case of accident or illness to my child and that I will make arrangements for medical care of my child with the physician or hospital of my choice.

If I cannot be reached to make the necessary arrangements or in a critical emergency requiring medical care, I hereby authorize SPECIAL LEARNING CENTER to contact:

(Please list the name/phone number of doctor, hospital OF YOUR CHOICE or both.)

Name of Doctor/Clinic: _____ Phone: _____
Address: _____
City/State/ZIP: _____

Preferred Hospital _____ Phone: _____
Address: _____
City/State/ZIP: _____

TRIP AND ACTIVITY PERMISSION:

- I do give consent for my child to take part in field trips with the Special Learning Center under proper supervision, and I will be notified when such trips are planned.
- I do not give consent for my child to take part in field trips with the Special Learning Center under proper supervision, and I will be notified when such trips are planned.

PHOTO RELEASE:

- I do hereby give my permission for pictures and/or information concerning me to be used by the Special Learning Center for educational purposes in newspapers, magazines, radio, television, or internet (website).
- I do not give my permission for pictures and/or information concerning me to be used by the Special Learning Center for educational purposes in newspapers, magazines, radio, television, or internet (website).

AGREEMENTS:

- a) The provider and I have agreed on a plan for continuing communication regarding my child’s development, behavior, etc.
- b) When my child is ill, it is understood and agreed that she/he may not be accepted for care.
- c) I have received and read a copy of the Special Learning Center’s Parent Handbook, which contains the Center’s policies and procedures.
- d) This certifies that this information is current and accurate to the best of my understanding.

Parent/Legal Guardian’s Signature

Date: _____