TOP TO BE FILLED IN BY PDO OFFICE ONLY:

Term: Fall 2017-2018 Date/Check#:_____ Registration Amt. Paid: _____ Tuition:_____

Age Level: 2 3 4 Days attending: 2 3 Sibling : Yes No Parishioner Non Parishioner

ENROLLMENT FORM

ST. ELIZABETH PARENT'S DAY OUT

2017-2018

Child's Name_____ **Date of Birth**_____

Name to be called_____ **Gender: Male _____ Female _____**

Address:_____

City: _____ **Zip Code:**_____

Home Phone:_____ **Allergies:**_____

Class choice (circle one) determined by child's age on 9/1/17: **2 days** (2, 3 or 4 year olds) **3 days** (only for 3 or 4 year olds)

Potty Trained? Yes_____ No_____ Working on it_____ All 4 year olds must be potty trained.

Mother's Name: _____ **Father's Name:**_____

D.L. #_____ **D.L. #** _____

Cell Phone:_____ **Cell Phone:** _____

Email: _____ **Email:** _____

Mother's Employer: _____ **Father's Employer:** _____

Work Phone: _____ **Work Phone:** _____

Occupation: _____ **Occupation:** _____

Names of current Legal Guardians: _____

Names and ages of siblings: _____

Is a sibling attending our program during the 2016-2017 school year? Yes _____ No_____

Pets: _____

Previous Program(s) attended: _____

Please share any information you feel would be helpful in understanding your child:

_____

_____

Name and relationship of person(s) responsible for bringing and/or picking up your child:

_____

Upon completion of the Enrollment Form, payment of Registration Fee and submitting an Immunization Record, a spot is reserved for your child to start in September 2017. If for any reason he/she will not be attending, it is your responsibility to let us know that they will not be attending. Until we receive such notice in writing, you will be responsible for any tuition which might occur.

Parent/Legal Guardian Signature:_____**Date:**_____

2017-2018 EMERGENCY FORM

ST. ELIZABETH PARENT'S DAY OUT

Student Information:

Child's Name:_____**Birthdate:**_____

Parents'/Legal Guardians' Names:_____

Home Address:_____

Home Phone:_____ **Cell Phone(s):**_____

Emergency Medical Contact:

Child's Physician:_____**Phone:**_____

Address of Physician's Office :_____

Medications being taken:_____

Known Allergies:_____

Persons other than parents/guardian authorized for child pickup and/or Emergency Contact:
(must name at least one and include name(s) listed on Enrollment Form other than parents)

Name:_____**D.L.#**_____**Phone:**_____
Address:_____

Name:_____**D.L.#**_____**Phone:**_____
Address:_____

Name:_____**D.L.#**_____**Phone:**_____
Address:_____

Name:_____**D.L.#**_____**Phone:**_____
Address:_____

Name:_____**D.L.#**_____**Phone:**_____
Address:_____

Name:_____**D.L.#**_____**Phone:**_____
Address:_____

EMERGENCY MEDICAL TREATMENT: In the event that I cannot be reached to make arrangements for emergency medical treatment, I authorize the Director or designated staff-in-charge to seek medical treatment for my child. I also agree that the Parish of St. Elizabeth of Hungary or any staff member cannot be legally held responsible for any accident or injuries incurred by my child while in their care.

Parent/Legal Guardian Signature:_____**Date:**_____