planet KIDS academy madisonville

ENROLLMENT APPLICATION

For Office Use Only

Start Date: _____

Classroom: _____

Child's Name: _____

Date of Enrollment: _____

Address: _____

City: _____ State: _____ Zip: _____

Child's Birth Date: _____ Preferred Name: _____

Mother or Guardian: _____

Mother's Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____ Driver's License #: _____

Place of Employment: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Business Phone #: _____ Ext.: _____ Hours: _____

Father or Guardian: _____

Father's Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____ Driver's License #: _____

Place of Employment: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Business Phone #: _____ Ext.: _____ Hours: _____

Expected Date for Attendance to Begin: _____

Who is Legally Responsible for Payment of Tuition: _____

In Case of an Emergency, Contact:

Name: _____ Phone #: _____

Driver's License #: _____ Relationship: _____

Approximate Drop-Off Time: _____

Approximate Pick-Up Time: _____

ATTENDANCE STATUS

- ❑ Full Day (includes hours 7:30 until 5:30)
- ❑ School Day (includes hours 9:00 until 4:00)

DAYS ATTENDING

❑ Three Days	M	T	W	TH	F
❑ Four Days	M	T	W	TH	F
❑ Five Days	M	T	W	TH	F

IDENTIFICATION AND EMERGENCY INFORMATION

Child's Physician: _____
Physician's Address: _____
City: _____ State: _____ Zip: _____
Physician's Phone: _____ Fax: _____
May we call another physician if we are unable to contact the above? _____
Dentist's Name: _____
Dentist's Phone : _____
All Special Needs, (Describe): _____

PERSON'S AUTHORIZED TO PICK UP CHILD:

Name: _____ Phone #: _____
Address: _____
City: _____ State: _____ Zip : _____

Name: _____ Phone #:_____
Address: _____
City: _____ State: _____ Zip : _____

Name: _____ Phone #: _____
Address: _____
City: _____ State: _____ Zip : _____

Name: _____ Phone #: _____
Address: _____
City: _____ State: _____ Zip : _____

OTHER EMERGENCY CONTACTS

Name: _____
Address: _____
City: _____
State: _____ Zip: _____

Name: _____
Address: _____
City: _____
State: _____ Zip: _____

Name: _____
Address: _____
City: _____
State: _____ Zip: _____

Name: _____
Address: _____
City: _____
State: _____ Zip: _____

MEDICAL HISTORY

List all allergies

1. _____
2. _____
3. _____
4. _____
5. _____

List any medical conditions

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Medical Insurance

Name of Company: _____
Policy Number: _____
Hospital Preference: _____