

Parent/Guardian Information

Enrollment Date: _____

Mother/Guardian Custodial Parent (If married, mark both parents)

First Name: _____ M.I. ___ Last Name: _____

Address: _____

Home Phone: () _____ Cell Phone: () _____

Occupation: _____ Employer: _____

Work Address: _____ Work Hours: _____

Office Phone: () _____

Mother's SS#: _____ Date of Birth: _____

Email: _____ Driver's License #: _____

Marital Status: Married Single Divorced Separated Widowed Other _____

Language Spoken: _____ Race & Ethnicity: _____

Father/Guardian Custodial Parent (If married, mark both parents)

First Name: _____ M.I. ___ Last Name: _____

Address: _____

Home Phone: () _____ Cell Phone: () _____

Occupation: _____ Employer: _____

Work Address: _____ Work Hours: _____

Office Phone: () _____

Father's SS#: _____ Date of Birth: _____

Email: _____ Driver's License #: _____

Marital Status: Married Single Divorced Separated Widowed Other _____

Language Spoken: _____ Race & Ethnicity: _____

How did you hear about Square One's programs?

Do any of the following options apply to your family?

_____ Advertisement
_____ Square One Web Page
_____ Family/Friend Referral
_____ DTA
_____ NEFWC

_____ Receiving Snap Benefits
_____ Teen Parent
_____ Open DCF Case
_____ DTA Cash Assistance
_____ Homeless
_____ Foster Parent / Guardian
_____ WIC
_____ Early Intervention or Special Educ. Services

Child Information

First Name: _____ M.I. _____ Last Name: _____

Child's Nickname: _____ Child's S.S. #: _____

Child's Address: _____

Gender: Male Female Date of Birth: _____

Photographs: May we take and maintain a photo of your child for security purposes (these are kept confidential and are used for internal purposes only)? Yes No

Race/Ethnicity:

Hair Color: _____ Eye Color: _____ Height: _____ Weight: _____

Identifying Marks:

Child Health Information

Allergies:

Chronic Health Conditions:

Family Preference:

Physician: _____
Address: _____ City: _____ Zip: _____
Phone: _____ Fax: _____
Insurance Company: _____

In the event of a MEDICAL EMERGENCY please transport my child to: _____.

Dentist: _____
Address: _____ City: _____ Zip: _____
Phone: _____ Fax: _____
Insurance Company: _____

Emergency Contacts & Authorized Pickup Persons:

All children are required to have at least two Emergency Contacts

1st Contact/Pick Up Name: _____ Phone: _____

Relationship to the Child: _____ PIN for check in/out (4 digits, numbers only) _____

Able to pick up all children in the family

Not able to pick up the following children: _____

2nd Contact/Pick Up Name: _____ Phone: _____

Relationship to the Child: _____ PIN for check in/out (4 digits, numbers only) _____

Able to pick up all children in the family

Not able to pick up this child

3rd Contact/Pick Up Name: _____ Phone: _____

Relationship to the Child: _____ PIN for check in/out (4 digits, numbers only) _____

Able to pick up all children in the family

Not able to pick up this child

4th Contact/Pick Up Name: _____ Phone: _____

Relationship to the Child: _____ PIN for check in/out (4 digits, numbers only) _____

Able to pick up all children in the family

Not able to pick up this child

Tuition / Payment Information:

Current Tuition Amount: _____ Weekly Bi-Weekly Monthly Other _____

Please outline below whom is responsible for payment of tuition and fees. Please fill out if parents are divorced and split tuition payment or if tuition payment is the responsibility of an adult other than the parents listed above.

Signature:

Parent/Guardian Signature: _____ Date: _____

Thank You!

Office Use Only:

Confirmed Enrollment Date: _____ Reviewed By: _____

Subsidy type: _____ Age Group/Classroom: _____

Transportation: AM PM