



ENROLLMENT FORM

1700 W. 32nd Street
Austin, TX 78703
(512) 467-8500
www.treetopslearning.com

Child's Name Last _____ First _____ Middle _____		Child's Date of Birth (mm/dd/yyyy)	Child's Primary Phone () ()	
Child's Home Address Street _____ City _____ State _____ ZIP _____				
Date of Admission (mm/dd/yyyy)		How did you learn about Tree Tops?		
PARENT 1 Mother / Father / Guardian (circle one) Authorized to pick-up child? <input type="checkbox"/> YES <input type="checkbox"/> NO Last _____ First _____ Middle _____			Address (if different from child's address) Street _____ City/State/ZIP _____	
Home Phone () ()	Work Phone () ()	Mobile Phone () ()	Driver's License (State/Number)	Email Address
PARENT 2 Mother / Father / Guardian (circle one) Authorized to pick-up child? <input type="checkbox"/> YES <input type="checkbox"/> NO Last _____ First _____ Middle _____			Address (if different from child's address) Street _____ City/State/ZIP _____	
Home Phone () ()	Work Phone () ()	Mobile Phone () ()	Driver's License (State/Number)	Email Address
Emergency Contacts If Parent/Guardian cannot be reached (At least two OTHER THAN Parent/Guardian)	Name (Last, First) Authorized to pick-up child? <input type="checkbox"/> YES <input type="checkbox"/> NO		Address Street _____ City/State/ZIP _____	
	Home Phone () ()	Work Phone () ()	Mobile Phone () ()	Relationship to Child
	Name (Last, First) Authorized to pick-up child? <input type="checkbox"/> YES <input type="checkbox"/> NO		Address Street _____ City/State/ZIP _____	
	Home Phone () ()	Work Phone () ()	Mobile Phone () ()	Relationship to Child
Authorized to Pick-Up Child	Name (Last, First)	Phone () ()	Name (Last, First)	Phone () ()

CHECK ALL THAT APPLY:

1. <input type="checkbox"/> WATER ACTIVITIES: I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give – my consent for my child to participate in Water Activities: <input type="checkbox"/> sprinkler play <input type="checkbox"/> splashing/wading pools <input type="checkbox"/> water table play
2. <input type="checkbox"/> RECEIPT OF WRITTEN OPERATIONAL POLICIES: I acknowledge receipt of the facility's operational policies.
3. I AUTHORIZE PHOTOS TO BE TAKEN OF MY CHILD FOR ANY SCHOOL RELATED USE, INCLUDING BUT NOT LIMITED TO NEWS MEDIA & PROMOTION, AND I RELEASE ALL RIGHTS, TITLE AND INTEREST IN THE FINISHED PHOTOS & NEGATIVES: <input type="checkbox"/> YES <input type="checkbox"/> NO
4. MY CHILD WILL BE IN CARE ON THE FOLLOWING DAYS AND TIMES: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Drop-In <input type="checkbox"/> Mondays <input type="checkbox"/> Tuesdays <input type="checkbox"/> Wednesdays <input type="checkbox"/> Thursdays <input type="checkbox"/> Fridays <input type="checkbox"/> 7:30am – 6:00pm <input type="checkbox"/> Other: _____

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION: In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:		
Name of Physician:	Address (Street, City, State, ZIP):	Ph.#: () ()
Preferred Hospital:	Address (Street, City, State, ZIP):	Ph.#: () ()
<input type="checkbox"/> I give consent for the facility to secure any and all necessary emergency medical care for my child.		

Signature – Parent or Legal Guardian

Date



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Page 2

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SPECIAL CARE NEEDS:

List any special problems that your child may have, such as **allergies**, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregiver's should be aware of:

Write "NONE" if there are no special care needs.

IMMUNIZATION RECORD:

I have provided the child care operation with a copy of my child's most current immunization record.

--- OR ---

SCHOOL AGE CHILDREN:

My child attends the following school AND his/her immunization record is on file at the school and all required immunizations and/or tuberculosis test are current. Vision and Hearing screening records are also on file.

_____ Name of School and Address _____ School Ph.#

ADMISSION REQUIREMENT: If your child does not attend pre-kindergarten or school away from the child-care operation, one of the following must be presented when your child is admitted to the child-care operation or within one week of admission.

HEALTH-CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he/she is able to take part in the day care program.

_____ Health Care Professional's Signature _____ Date

Name and address of health care professional:

--- OR ---

My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and will submit it to the child-care operation.

_____ Signature – Parent or Legal Guardian _____ Date