

ESUMC Early Childhood Program  
Enrollment Application

Name of Child \_\_\_\_\_ Birth date \_\_\_\_\_

Address \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ Zip Code \_\_\_\_\_

Email Address (please print clearly) \_\_\_\_\_

**Family Information:**

Father/Guardian Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Nature of Business \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mother/Guardian Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Nature of Business \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Child Information**

Please list any allergies, medications, or treatments your child receives:

\_\_\_\_\_  
\_\_\_\_\_

My child's immunizations are up to date. Yes \_\_\_\_\_ No \_\_\_\_\_ please contact the director to discuss this if answering no.

**Emergency Information**

Child's Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Child's Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Hospital Preference \_\_\_\_\_

If family members listed above cannot be reached in case of an emergency, list **at least three** persons that we may contact.

Name \_\_\_\_\_ Phone # (s) \_\_\_\_\_

Name \_\_\_\_\_ Phone # (s) \_\_\_\_\_

Name \_\_\_\_\_ Phone # (s) \_\_\_\_\_

Please list names of people to whom your child can be released:

\_\_\_\_\_

I agree that the Director, Assistant Director, or Designee may authorize the physician of his/her choice to provide emergency care in the event that neither parent nor the family physician can be contacted immediately.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_