Bethesda Child Development Center
116 East Main Street
Middletown, Delaware 19709
(302) 378-8435 / (302) 378-7613 fax

ENROLLMENT FORM (PAGE 1 OF 2)

Date Child Started: _____ Date Child Ended: _____

Registration: _____

Arrival Time: _____ Depart Time: _____

Program: _____ Site/Room: _____

(Above For Office Use Only)

CHILD'S FULL NAME _____ BIRTH DATE _____ HOME PHONE # _____

STREET _____ CITY _____ ZIP _____

PRIMARY GUARDIAN _____ RELATIONSHIP TO CHILD _____

EMPLOYER NAME _____ WORK HOURS _____

BUSINESS PHONE _____ CELL PHONE _____

E-MAIL _____

SECONDARY GUARDIAN _____ RELATIONSHIP TO CHILD _____

EMPLOYER NAME _____ WORK HOURS _____

BUSINESS PHONE _____ CELL PHONE _____

E-MAIL _____

***Lives with** ☐ **Mother** ☐ **Father** ☐ **Grandparents** ☐ **Other** _____ **(Check all that apply)**

***Are there any custodial arrangements for this child?** ☐ **Yes** ☐ **No** **(If yes, copies of legal documentation must be submitted.)**

If not available in an emergency, notify:

(Please note-Those listed here are considered authorized child release people and must be 18 years or older for emergency pick-up.)

1. Name: _____ Relationship: _____ Phone: _____
2. Name: _____ Relationship: _____ Phone: _____

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the Bethesda Child Development Center director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child as named above. I understand I will be financially responsible for the cost of such treatment.

PARENT/GUARDIAN SIGNATURE _____ **Date** _____

FAMILY PHYSICIAN _____ **Phone** _____

CHILD RELEASE- MUST BE 16 YEARS OLD OR OLDER TO PICK UP CHILDREN FROM BCDC PROGRAMS

The following additional people are authorized to pick up my child from Bethesda Child Development Center:

	NAME	CELL	WORK
1.			
2.			
3.			
4.			
5.			

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

ALL DEPOSITS AND REGISTRATION FEES ARE NON-REFUNDABLE. ALL FORMS AND FEES NEED TO BE IN THE BCDC OFFICE BY NOON ON WEDNESDAY TO BEGIN ON THE NEXT MONDAY. (CA_____/PC_____/AA_____/FM_____)

RETURNING: _____ INFO CHANGED? _____ NEW: _____

HEALTH APPRAISAL

Complete the following & give additional comments if needed:

CHILD'S MEDICATIONS _____

CHILD'S MEDICAL ALLERGIES _____

CHILD'S FOOD ALLERGIES _____

Additional Information about your child (includes, serious illness, accidents, operations, etc., with dates)

_____

_____

_____

Does your child have a current Individualized Education Program (IEP) through Appoquinimink School District?

☐ Yes ☐ No

Does your child have a current Section 504 of the Rehabilitation Act plan? ☐ Yes ☐ No

What is your child's primary language? _____

Does your child have a secondary language? _____

Please share with BCDC any religious or cultural traditions your family observes or does not observe throughout the year: _____

GUARDIAN SIGNED RELEASES

- **Photo Release**: I hereby give my permission for my child to be photographed, videotaped and/or audio taped while engaging in BCDC activities. I hereby give my permission for these photographs, videos, and/or audio to be used as BCDC needs. I.E. Facebook, advertising, curriculum, in the community, etc.

  PARENT/GUARDIAN SIGNATURE_____ **DATE** _____

- **Tadpoles**: I acknowledge and give permission for BCDC to utilize the Tadpoles program with my child.

  PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

- **Transportation Release:** I hereby give my permission for my child to be transported by BCDC in an emergency situation.

  PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

SCHOOL MESSENGER PHONE NUMBERS

Please list below the two phone numbers you would like to be used for our School Messenger system.

1. _____ 2. _____