

# TOP Learning Center Enrollment Form

## Child's Information

Child's Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Child's Nick-Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 Child's Social Security Number: \_\_\_\_\_ Sex: \_\_\_\_\_

## Parent's Information

Please circle which one applies to you:                      Single                      Married

### Mother or Lawful Custodian

**Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City, State, Zip:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_  
**Cell Phone:** \_\_\_\_\_  
**Mom's SS#** \_\_\_\_\_

### Father or Lawful Custodian

**Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City, State, Zip:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_  
**Cell Phone:** \_\_\_\_\_  
**Dad's SS#** \_\_\_\_\_

## Employment Information

### Mother or Lawful Custodian's Employment

**Company:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City, State, Zip:** \_\_\_\_\_  
**Work Phone:** \_\_\_\_\_ **Work Hrs:** \_\_\_\_\_  
**Working Days (circle):** M Tu W Th F

### Father or Lawful Custodian's Employment

**Company:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City, State, Zip:** \_\_\_\_\_  
**Work Phone:** \_\_\_\_\_ **Work Hrs:** \_\_\_\_\_  
**Working Days (circle):** M Tu W Th F

## Emergency Information

Person(s) to contact who are authorized to pick up child in case of an emergency or illness if Parent(s) or Lawful Custodian(s) is unavailable or cannot be reached by calling the numbers given to us on this form.

<b>Name:</b> _____ <b>Address:</b> _____ <b>City, State, Zip:</b> _____ <b>Phone:</b> _____ <b>Relationship:</b> _____	<b>Name:</b> _____ <b>Address:</b> _____ <b>City, State, Zip:</b> _____ <b>Phone:</b> _____ <b>Relationship:</b> _____
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In addition to the Parent(s) or Lawful Custodian(s) and the above emergency contacts, list persons & phone numbers authorized to pick up a child at school:

<b>Name:</b> _____ <b>#</b> _____	<b>Name:</b> _____ <b>#</b> _____
<b>Name:</b> _____ <b>#</b> _____	<b>Name:</b> _____ <b>#</b> _____

**Nationality:** (please circle all that apply to you)    United States                      Other: \_\_\_\_\_

**Ethnicity/Race:** (please circle all that apply to you)    Caucasian                      Hispanic                      Asian  
 Pacific Islander                      African                      Native American                      Other: \_\_\_\_\_

## Authorization for Emergency Medical Care for TOP Learning Center

### Please Note:

- 1 This form is to be completed by Parent or Legal Guardian
- 2 This form must be signed in the presence of a Witness who is **not related to the person signing** and **who is not an employee of TOP** Learning Centers. This form will **not** be accepted without the signature of the Witness as well as the Parent or Guardian.
- 3 You must fill out all of the medical information below, including the last TETANUS TOXOID. You can get this date from your child's last DPT shot record.

In order to meet all legal requirements, I hereby authorize Janice Smith and/or the staff of TOP Learning Center as representatives of TOP Learning Center to give consent for any and all necessary emergency medical care for my child, whose name is \_\_\_\_\_ while said child is in said individual's custody beginning on the first day of enrollment and ending when child is no longer enrolled.

Parent Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

WITNESS Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

### Medical Information

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

### Emergency Contact Phone Numbers

Mother Home #: \_\_\_\_\_ Father Home #: \_\_\_\_\_

Mother Work #: \_\_\_\_\_ Father Work #: \_\_\_\_\_

### Health Insurance Information

Health Insurance Carrier: \_\_\_\_\_ ID #: \_\_\_\_\_

Does your child qualify for Military Medical Care? \_\_\_\_\_ If so, ID#: \_\_\_\_\_

Do you receive Medical Assistance through SRS? \_\_\_\_\_ If so, ID#: \_\_\_\_\_

Is your child allergic to any drugs? \_\_\_\_\_ If so, what? \_\_\_\_\_

Is your child allergic to and foods? \_\_\_\_\_ If so, what? \_\_\_\_\_

Date of your child's MOST RECENT Tetanus Toxoid Shot(or DTP)? \_\_\_\_\_

This form will be attached to your child's health records.

Both forms will be taken to the emergency room.