HOUSE OF ANGELS FAMILY CHILDCARE

CHILD CARE APPLICATION FOR EMROLLMENT

Student Information: Date of Birth: _____ Sex: _____

Date of Enrollment: _____

Full Name: _____
Last First Middle Nickname

Child's Physical Address: _____

Primary Hours of Care: From: _____ To: _____

Days of the Week in Care: M T W TH F SA SU

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Family Information: Child lives with: _____

Mother's Name: _____ Father's Name: _____

Address: _____ Address: _____

Home Phone: _____ Home Phone: _____

Employer: _____ Employer: _____

Address: _____ Address: _____

Work Phone: _____/Cell: _____ Work Phone: _____/Cell:_____

Custody: Mother _____ Father _____ Both _____ Other _____

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Medical Information: Physician to be called in an emergency

Doctor:_____Address:_____Phone:_____

Dentist:_____Address:_____Phone:_____

If physician cannot be reached what action should be taken?
___ Call Emergency Hospital ____ Other Plan_____

Does your child have an IEP or IFSP? Yes ___ or No ___ If yes we request that you provide HOAFCC with a copy as we work with families and special education service providers to support child and family outcomes.

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Contacts: Name of Persons Authorized to take child from FCC home. Child will not be allowed to leave with any other person without written authorization from parent or guardian.

Name	Relationship

_____ _____

Signature of Sponsor/ Guardian **Date**