



# Enrollment Form Discovery Time Preschool

1932 Burton St.  
PO Box 118  
Strasburg, CO 80136  
(303) 622-4260

11:56 AM  
8/19/2009

### Family Information

LAST	FIRST	MI
<input type="text"/>	<input type="text"/>	<input type="text"/>
RELATION	SSN	
<input type="text"/>	<input type="text"/>	
ADDRESS1		
<input type="text"/>		
ADDRESS2		
<input type="text"/>		
CITY	STATE	ZIP
<input type="text"/>	<input type="text"/>	<input type="text"/>
HOME PHONE	WORK	EXT
<input type="text"/>	<input type="text"/>	<input type="text"/>
CELL	EMAIL	
<input type="text"/>	<input type="text"/>	

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HOME PHONE	WORK	EXT
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CELL	EMAIL	
<input type="text"/>	<input type="text"/>	

### Child Information

LAST	FIRST	MI
<input type="text"/>	<input type="text"/>	<input type="text"/>
SEX	ETHNICITY	BIRTHDAY
<input type="text"/>	<input type="text"/>	<input type="text"/>
EMG CONTACT	EMG PHONE	
<input type="text"/>	<input type="text"/>	
EMG CONTACT	EMG PHONE	
<input type="text"/>	<input type="text"/>	
DR'S NAME	DR'S PHONE	
<input type="text"/>	<input type="text"/>	
INS PROVIDER	POLICY	
<input type="text"/>	<input type="text"/>	
BLOOD TYPE	LAST PHYSICAL	
<input type="text"/>	<input type="text"/>	
ALLERGIES		
<input type="text"/>		

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<input type="text"/>	<input type="text"/>	
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<input type="text"/>	<input type="text"/>	
ALLERGIES		
<input type="text"/>		

### EMERGENCY AUTHORIZATION

State law requires that we have written authorization from a child's legal guardian to seek medical help in the event of a medical emergency. Signing the statement at the bottom of this letter will provide us with that authorization.

Our policy, in the event of a medical emergency is to contact you first. If we can't contact you, we will try to contact any others you may designate. In the event that we are unable to contact you or your designated representative(s), or if the medical emergency warrants immediate response, we will act, on your behalf and in the best interests of the child.

Please sign here: \_\_\_\_\_  
Signature Date

### OFFICE USE ONLY

Tuition: \$ _____	Classroom: _____	Enrolled: _____
Billing cycle: _____	Program: _____	