



Child's Name: \_\_\_\_\_

Gender:  Male  Female

Date of Birth: \_\_\_\_\_

Enrollment/Start Date: \_\_\_\_\_

Classroom: \_\_\_\_\_ Program: \_\_\_\_\_

Location: \_\_\_\_\_

**ENROLLMENT AGREEMENT**

**Parent/Guardian Information:**

**1<sup>st</sup> Guardian- Party Responsible for Tuition Payments**

Name: _____	DL#: _____
Address: _____	City: _____ State: <u>TX</u> Zip: _____
Cell #: _____	Home #: _____ Work#: _____
Employer: _____	Work Hours: _____
4 Digit Code: _____	E-Mail: _____

**2<sup>nd</sup> Guardian-**

Name: _____	DL#: _____
Address: _____	City: _____ State: <u>TX</u> Zip: _____
Cell #: _____	Home #: _____ Work#: _____
Employer: _____	Work Hours: _____
4 Digit Code: _____	E-Mail: _____

**Designated Contact Information:**

Please list and alternate contact in case of emergency and parents/guardian cannot be reached.

Name: _____	City: _____	State: _____	Zip: _____
Address: _____	Home #: _____	Work#: _____	
Cell #: _____	Relationship _____		

**Authorized Pick Up:**

Children will only be released to a parent or person designated by the parent or guardian after verification of ID. I authorize Imagine Nation Learning Center to allow my child to leave the center ONLY with the following persons:

Name:	Relationship	Home Phone	Alternate Phone	Photo ID on File

How did you hear about us? \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **Allergies**

Does your child have any allergies or special diets? YES      NO

Please list:

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Please explain the reaction your child has if he/she comes in contact with or ingests any of the item(s) above.

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## **Special Needs**

Please list any special needs that your child may have, such as existing illness, previous serious illness, injuries and hospitalizations during the past twelve months, and medication prescribed for long-term continuous use, and any other information that caregivers should be aware of:

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## **Emergency Medical Authorization**

I give permission for Imagine Nation Learning Center to seek medical attention, including transport by EMS if necessary, for my child, \_\_\_\_\_, in the event of an emergency if I cannot be reached, and to hold harmless and release Imagine Nation Learning Center and its employees from liability. I further agree to keep the facility informed of changes in telephone numbers, etc. where I can be reached.

X

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Parent Sign and Date

## **Physician's Information**

Name:	_____	City:	_____	State:	_____	Zip:	_____
Address:	_____						
Phone#:	_____	Fax #:	_____				

## **Medical Records**

I understand that Imagine Nation Learning Center is required to have a copy of my child's updated shot records. A copy must be turned in with this enrollment package. I must also provide a written pre-school health statement from my health care professional. If my child is four (4) years old by September 1<sup>st</sup>, I must also provide the center with vision and hearing screening results completed by a healthcare professional.

-or-

My child, \_\_\_\_\_, attends public/private school and has a current immunization and vision/hearing screening record on file at school.

School:	_____	City:	_____	State:	_____	Zip:	_____
Address:	_____						
Phone#:	_____	Grade	_____	Teacher:	_____		

X

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Parent Sign and Date