| The Starting Point  |                      |                  |                     | 64 NJ-37 Suite 16<br>s River, NJ 08755<br>(732) 341-3177 |
|---|----------------------|------------------|---------------------|--|
| <u>Student Enrollment Form</u><br>Non-refundable application fee: \$50 (please make check payable to Alphabets Daycare and Preschool) |                      |                  |                     |  |
| Anticipated student start D   | Date: Today's Date:  |                  |                     |  |
| Child Information:  |                      |                  |                     |  |
|   |                      |                  |                     |  |
|   |                      |                  |                     |  |
|   |                      |                  |                     |  |
|   | Home Phone:          |                  | Student lives with: |  |
| Child's Siblings (Names and   | age):                |                  |                     |  |
| Parent/Guardian Information   | on:                  |                  |                     |  |
| Name:   |                      |                  | Relation:           |  |
|   |                      |                  |                     | Zip:   |
|   | Cell:                |                  |                     |  |
|   |                      |                  |                     |  |
|   | Occupation:          |                  |                     |  |
| Name:   |                      |                  | Relation:           |  |
|   |                      |                  |                     | Zip:   |
|   | Cell:                |                  |                     |  |
|   |                      |                  |                     |  |
| Employer:   | Occupation:          |                  |                     |  |
| Emergency Contact Informa   | ation:               |                  |                     |  |
| Nome  |                      |                  | Deletion            |  |
| Name:<br>Address:   |                      | City             | Relation:           | Zini   |
|   | Cell:                | City             |                     | ZIP  |
|   | ccm                  |                  | WOTK                |  |
| Name:   |                      |                  | Relation:           |  |
| Address:  |                      | City:            | State:              | Zip:   |
| Home Number:  | Cell:                |                  | Work:               |  |
| Physician Information:  |                      |                  |                     |  |
| Name:   |                      | Hospital Affilia | ation:              |  |
|   |                      |                  |                     |  |
|   | Allergies (including |                  |                     |  |
|   | Policy No.:          |                  |                     |  |
| Special Disabilities (if any):  |                      |                  |                     |  |
| Special Disabilities (if any):<br>Additional Information for Special Needs:   |                      |                  |                     |  |
| Medical Special Conditions:   |                      |                  |                     |  |
| Medical or Dietary Information Needed in An Emergency Situation:  |                      |                  |                     |  |
|   |                      |                  |                     |  |

