

SAINT FRANCIS XAVIER CATHOLIC CHURCH  
EARLY LEARNING CENTER  
CHILD ENROLLMENT FORM

Name of Child \_\_\_\_\_ Birthdate \_\_\_\_\_

Home Address \_\_\_\_\_ Zip \_\_\_\_\_ Telephone \_\_\_\_\_

Parent (or guardian) Father's Name \_\_\_\_\_

Mother's Name \_\_\_\_\_

Marital Status of Parents: ( ) Married ( ) Divorced ( ) Separated ( ) Single ( ) Widow ( ) Widower

Person Having custody of child \_\_\_\_\_  
(Copy of custody papers must be on file)

Father's Place of Employment \_\_\_\_\_

Business Address \_\_\_\_\_ Telephone \_\_\_\_\_

Father's Cell Phone \_\_\_\_\_ E-MAIL \_\_\_\_\_

Mother's Place of Employment \_\_\_\_\_

Business Address \_\_\_\_\_ Telephone \_\_\_\_\_

Mother's Cell Phone \_\_\_\_\_ E-MAIL \_\_\_\_\_

Church Affiliation:

Father: \_\_\_\_\_ Mother \_\_\_\_\_

Name, Address and telephone number of person, other than custodial parent to contact and release child to in case of emergency:

NAME	ADDRESS	PHONE	RELATION TO CHILD
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1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Program Registration

Name of Child: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age of child on Sept.1 \_\_\_\_\_

Sibling Information:

Name Age

Name Age

Name Age

Program Registration: Circle Days Needed

- 4 K Full Day (7:45-3:00)
- 4 K Half Day (9:00-1:00)
- 3K Program (9:00-1:00) Monday Tuesday Wednesday Thursday Friday
- 3 Year Old Program (9:00-1:00) Monday Tuesday Wednesday Thursday Friday
- 2 Year Old Program (9:00-1:00) Monday Tuesday Wednesday Thursday Friday
- Toddler Program (9:00-1:00) Monday Tuesday Wednesday Thursday Friday

Before Care/After Care Options: Please mark if you will use these programs on a regular basis:

- Before Care- 7:30 a.m.-9:00 a.m. Circle days needed: Mon Tues Wed Thurs Fri
- After Care- 1:00 p.m.-3:00 p.m. Circle days needed Mon Tues Wed Thurs Fri
- Extended Care- 3:00- 6:00 p.m. Circle days needed Mon Tues Wed Thurs Fri

**REGISTRATION AND PROGRAM FEES**  
**ARE NON-REFUNDABLE**

CHILD'S HEALTH HISTORY AND MEDICAL FORM

Child's Name: \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_ Telephone \_\_\_\_\_

Child's Physician \_\_\_\_\_ Telephone \_\_\_\_\_

Has your child ever been hospitalized? \_\_\_\_\_ If so, please describe \_\_\_\_\_

Has your child ever been seriously injured? \_\_\_\_\_ If so, please describe \_\_\_\_\_

Is your child on any medications daily? \_\_\_\_\_ If so, please describe \_\_\_\_\_

Does your child have allergies (food, environmental, seasonal)? \_\_\_\_\_

If so, please describe a reaction to the allergen \_\_\_\_\_

What action do you wish us to take if an allergic reaction occurs? \_\_\_\_\_

Are there any other medical/health issues we should know about your child? \_\_\_\_\_

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