

**Shelby Hills Early Childhood Center**

1200 S. Children's Home Rd.  
 Sidney, OH 45365  
 937-498-4565 \* FAX 937-498-0085

[www.shelbydd.org](http://www.shelbydd.org)

**CHILD ENROLLMENT INFORMATION**

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

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Cell Phone \_\_\_\_\_ TEXTING \_\_ yes \_\_ no

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Employer Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Medicaid # \_\_\_\_\_ EMAIL \_\_\_\_\_

Please circle which phone number should be used 1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> to reach you while your child is in the program.

Home 1 2 3      Cell 1 2 3      Work 1 2 3

Parent/Guardian \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Employer Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Please circle which phone number should be used 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup> to reach you while your child is in the program.

Home 1 2 3      Cell 1 2 3      Work 1 2 3

Please list two people to be contacted in the event of an emergency **IF THE PARENT CANNOT BE CONTACTED:**

Name	Name
Street Address	Street Address
City	City
State                                  ZipCode	State                                  ZipCode
Relationship to Child	Relationship to Child
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:

**Physician:**

**Dentist:**

Name	Name
Street Address	Street Address
City, State, Zipcode	City, State, Zipcode
Phone	Phone

PLEASE COMPLETE BACK OF PAGE →

**ANNUAL CLASS ROSTER & PHOTO PERMISSION:**

Each year we prepare a roster for each group of children in our program. This roster will not be furnished to any persons other than parents of children enrolled in our program.

I authorize the following to be listed on the parent roster:

Please circle one		
My Child's Name	Yes	No
Parent/Guardian's Name	Yes	No
Phone Number	Home	Cell Work
Photo Release	Yes	No

\_\_\_\_\_  
*Signature of parent/guardian (must be signed and dated)*

\_\_\_\_\_  
*Date Signed*

<i>CHRONIC PHYSICAL PROBLEM (S):</i>
<i>HISTORY OF HOSPITALIZATION:</i>
<i>DISEASES THIS CHILD HAS HAD:</i>
<i>ALLERGIES AND TREATMENT:</i>
<i>MEDICATIONS, FOOD SUPPLEMENTS, MODIFIED DIET OR FLUORIDE SUPPLEMENTS:</i>

List of Person(s) to whom this child can be released: (Please print)


List of Person(s) **NOT PERMITTED** to pick up this child: (Please print)

Restraint papers/divorce decree attached

	YES	NO
	YES	NO
	YES	NO

**IMPORTANT: Please attach a copy of your child's immunization records**

EXEMPT FROM IMMUNIZATIONS	PLEASE CIRCLE ONE	
	YES	NO
Religious conviction		
Other:		

Parent/Guardian's signature for immunization exemption:

\_\_\_\_\_