For office use:
Enrollment date_____ First day of attendance _____

LAMBS OF CHRIST LEARNING CENTER

Toddler Program *(ages 12-24 months)*

REGISTRATION FORM

Child's name: _____
Last First Middle Initial

Birth date (month/day/year): _____ Boy_____ Girl _____

Home address _____

City, state & zipcode_____

Home telephone number (_____)_____-_____

Minimum attendance is two days per week, 8:30-11:30 am. Wraparound care is available 6:30 -8:30 am and 11:30 am – 5:30 pm.
Please mark the day(s) your child will be attending and indicate times for drop off and pick up if they will arrive before 8:30 or stay for care after 11:30.

	Drop off (if before 8:30)	Pick up (if after 11:30)
☐ Monday		
☐ Tuesday		
☐ Wednesday		
☐ Thursday		
☐ Friday		

You will be charged for the days and times you have listed.
Please indicate a payment method:

___Automatic Withdrawal (Tuition Express)

___Point of Sale

For office use:
___Registration fee received.

_____
Date

Provide email addresses to receive statements and newsletters electronically.

email address: _____ (Primary contact)

email address: _____ (Second contact if desired)

PARENT OR GUARDIAN INFORMATION

Mother's name: _____Telephone#: _____

Address (street, city, state, zip):_____

_____

Place of employment or other location where mother can be contacted while child is in care:

_____Telephone #: _____

Father's name: _____Telephone#: _____

Address (street, city, state, zip):_____

_____

Place of employment or other location where father can be contacted while child is in care:

_____Telephone #: _____

If applicable, complete guardian information.

Name: _____Telephone#: _____

Address (Street, City State, Zip):_____

_____

Telephone number: _____

Place of employment or other location where guardian can be contacted while child is in care:

_____Telephone #: _____

PERSONS OTHER THAN PARENTS/GUARDIANS WHO ARE AUTHORIZED TO PICK UP CHILD
Is anyone other than a parent or guardian authorized to pick up the child? __Yes __No
If yes, provide information requested for each person.

Name: _____

Telephone#: _____ Relationship to child: _____

Address (street, city, state, zip) _____

_____

Name: _____

Telephone#: _____ Relationship to child: _____

Address (street, city, state, zip) _____

_____

EMERGENCY CONTACT
Provide information for the person to contact when a parent/ guardian cannot be reached.

Name: _____

Telephone#: _____ Relationship to child: _____

Address (street, city, state, zip) _____

_____

Place of employment or other location where contact can be reached while child is in care:

_____Telephone #: _____

___ **Yes** this person is authorized to pick up the child.

___ **No** this person is not authorized to pick up the child.

MEDICAL CARE PROVIDERS

Physician: _____

Address: _____ Phone: _____
Street City

Family Dentist: _____

Address: _____ Phone: _____
Street City

Hospital: _____

Address: _____ Phone: _____
Street Cit

AUTHORIZATIONS

I hereby give my consent for emergency medical care or treatment to be used if I cannot be reached immediately. ___ **Yes** ___ **No**

I have had an opportunity to review the policies of this childcare center and a summary of the Wisconsin Rules for Licensing Child Care Centers. ___ **Yes** ___ **No**

I understand that Lambs of Christ staff may take my child's photograph for use in advertising and promotion, that children in photos are not identified by name, and I consent to the use of my child's photo as follows:

In-house promotions: ___ **Yes** ___ **No**

Community advertising, such as local newspaper or stores: ___ **Yes** ___ **No**

Facebook posts: ___ **Yes** ___ **No**

Website/Web stream (: ___ **Yes** ___ **No**

FAMILY INFORMATION

Please list your child's siblings:

Child's name: _____ Age: _____ Male/Female

Child's name: _____ Age: _____ Male/Female

Child's name: _____ Age: _____ Male/Female

Child's name: _____ Age: _____ Male/Female

Family religion: _____

Church Affiliation: _____

Is your child baptized? ___ Yes ___ No

_____ _____
Signature of Parent or Guardian Date