



CHAMBLISS CENTER FOR CHILDREN
GROWING YOUNG LIVES 24•7•365

Application for Childcare

Date:			Visit Date:		
Child Name:			Siblings on List: Yes <input type="checkbox"/> No <input type="checkbox"/>		
DOB:		Race:		SS Number:	
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Family Income:	School:	Memo:	Certificate Yes <input type="checkbox"/> No <input type="checkbox"/>	
Email:		MOTHER		FATHER	
Name					
Address					
Marital Status		Single: <input type="checkbox"/> Married: <input type="checkbox"/> Unmarried Couple: <input type="checkbox"/> Divorced: <input type="checkbox"/> Widowed: <input type="checkbox"/>			
Home phone number					
Cell phone number					
Employer					
Work phone number					
Schedule					
MEDICAL INFORMATION:					
Child's Primary Care Physician:			Phone Number:		
Medical Diagnosis and treatment, if any:					
Child's allergies and treatment, if any:					
EMERGENCY CONTACTS AND PERSONS AUTHORIZED TO PICK UP CHILDREN					
Name:		Relationship:		Phone:	
Name:		Relationship:		Phone:	
Name:		Relationship:		Phone:	
Enroll Date:			Classroom:		
Days of Care:			Hours of Care:		
Enrollment Packet Yes <input type="checkbox"/> No <input type="checkbox"/>			Orientation Information Yes <input type="checkbox"/> No <input type="checkbox"/>		