



State of Florida
Department of Children and Families

CHILD CARE APPLICATION FOR ENROLLMENT

Student Information:

Date of Birth: _____ Sex _____
Date of Enrollment: _____

Full Name: _____
Last First Middle/Initial Nickname

Child's Address: _____

Primary Hours of Care: From: _____ To: _____

Family Information:

Child Lives With: _____

Mother's Name: _____

Father's Name: _____

Home Address: _____

Home Address: _____

Home Phone: _____

Home Phone: _____

Employer: _____

Employer: _____

Employer's Addr: _____

Employer's Addr: _____

Work Phone: _____

Work Phone: _____

Medical Information:

I hereby grant permission for the staff of this facility to contact the following medical personnel to obtain emergency medical care if warranted.

Doctor: _____

Address: _____

Doctor: _____

Address: _____

Dentist: _____

Address: _____

Hospital Preference _____

Please list allergies, special medical or dietary needs, or other areas of concern: _____

Contacts:

Child will be released only to the custodial parent or legal guardian and the persons listed below. The following people will also be contacted are authorized to remove the child from the facility in case of illness, accident, or emergency, if for some reason the custodial parent or legal guardian cannot be reached:

Name Address Work # Home #

Name Address Work # Home #

Name Address Work # Home #

Name Address Work # Home #

Custody: Mother _____ Father _____ Both _____ Other _____