

# MY SPECIAL SPOT 2024-2025 ENROLLMENT APPLICATION



CHILD'S FULL Name		NICKNAME		D.O.B. OR DUE DATE	
PRIMARY LANGUAGE		DO RELEVANT CUSTODY PAPERS APPLY? ( ) YES ( ) NO		GENDER	
ADDRESS – STREET, CITY, STATE, ZIP					
DESIRED SCHEDULE (PLEASE CIRCLE DAYS) M T W Th F		ARRIVAL TIME		DEPARTURE TIME	
PARENT/LEGAL GUARDIAN'S NAME				HOME PHONE	
HOME ADDRESS – STREET, CITY, STATE, ZIP				WORK PHONE	
				CELL PHONE	
EMPLOYER NAME			WORK HOURS		EMAIL FOR CLOSINGS/DELAYED OPENINGS/NOTICES
EMPLOYER ADDRESS					
PARENT/LEGAL GUARDIAN'S NAME				HOME PHONE	
HOME ADDRESS – STREET, CITY, STATE, ZIP				WORK PHONE	
				CELL PHONE	
EMPLOYER NAME			WORK HOURS		EMAIL FOR CLOSINGS/DELAYED OPENINGS/NOTICES
EMPLOYER ADDRESS					

### EMERGENCY INFORMATION

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER		TELEPHONE	HOSPITAL AFFILIATION
PHYSICIAN/MEDICAL CARE PROVIDER ADDRESS, STREET, CITY, STATE, ZIP			
ALLERGIES(INCLUDING MEDICATION REACION)		MEDICATION, SPECIAL CONDITIONS	
SPECIAL NEEDS/DISABILITIES (IF ANY)			
MEDICAL OR DIETARY INFROMATION NECESSARY IN AN EMERGENCY SITUATION			
HEALTH INSURANCE COVERAGE FOR CHILD OR MEDICAL ASSISTANCE BENEFITS		POLICY NUMBER (REQUIRED)	

### EMERGENCY CONTACT PERSON(S) TO WHOM THE CHILD MAY BE RELEASED IN CASE OF ILLNESS OR EMERGENCY IF PEOPLE ABOVE CANNOT BE CONTACTED

NAME	FULL ADDRESS	RELATIONSHIP	DAYTIME PHONE #
1.			
2.			
3.			

### CONSENT TO CARE AND TREAT

It is our firm hope that the authorization granted in this form will never need to be used. For the safety of the children, however, sound medical practice calls for such permission. The authorization granted by this form will be used only when absolutely necessary. Every effort will be made to contact a parent. All children, whether at home or at school, are at risk for falls, bumps, bruises, scrapes and such boo-boos are a normal part of typical childhood play. While we exceed the State required child-to-teacher ratios and provide what we believe to be the highest standards of care and supervision, accidents can still happen. Your signature on this form will act as a Release and Waiver of Liability of My Special Spot, its owners, director, and employees, for any injuries which your child may incur while under the care and supervision of My Special Spot, unless such injury is the direct result of our gross and extreme negligence, or willful and wanton acts.

I/We authorize The Center to administer minor first-aid or obtain emergency medical care for my child in case of an accident or acute illness (the determination thereof shall rest entirely with The Center). I/We authorize The Center to take my child's temperature as needed. I understand that only external methods will be used such as forehead, underarm, or ear method, and that The Center is not responsible for any lack of accuracy in the readings which may result. I hereby give permission to have my child, \_\_\_\_\_ taken to \_\_\_\_\_ hospital or any other nearby medical facility. I expect that in such an event, I will be notified ASAP.

### PARENT'S/LEGAL GUARDIAN'S SIGNATURE

**X**

**THIS APPLICATION MUST BE ACCOMPANIED BY A NON REFUNDABLE REGISTRATION FEE OF \$150.00 AND A \$500 SECURITY DEPOSIT TO HOLD THE SPOT. IF YOUR CHILD DOES NOT START WITHIN 30 DAYS OF YOUR DESIRED START DATE, YOUR SPOT WILL NO LONGER BE GUARANTEED AND YOUR DEPOSIT AND REG. FEE WILL BE FORFEITED.**

<b>FOR SCHOOL USE ONLY</b>	GROUP _____		MONTHLY TUITION _____		PROMO DISCOUNT _____	
	DATE PAID _____		<input type="checkbox"/> CASH	<input type="checkbox"/> CHECK # _____	SECURITY DEP. _____	REG. FEE _____ 1 <sup>ST</sup> MO. TUITION _____