

**STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH
FAMILY DAY CARE LICENSING**

CHILD ENROLLMENT FORM

Child's Name: _____ Child's Date of Birth: _____	
Home Telephone #: _____ Date of Application: _____	
Father's Name: _____ Date Enrolled: _____	
Mother's Name: _____ Date Enroll Ends: _____	
Mother's Address: _____ City: _____	
Mother's Employer: _____ Work Phone #: _____	
Mother's Employer Address: _____ City: _____	
Father's Address (if different): _____ Phone #: _____	
Father's Employer: _____ City: _____ Work Tel.: _____	
Father's Employer Address: _____ City: _____	
Weekly Care Schedule: Day: _____ Begin: _____ End: _____ _____ Sunday: _____ Monday: _____ Tuesday: _____ Wednesday: _____ Thursday: _____ Friday: _____ Saturday: _____	Persons to Call in an Emergency: Name: _____ Address: _____ _____ Phone #: _____ Relationship: _____ -----◆----- Name: _____ Address: _____ Phone #: _____ Relationship: _____
_____, my child care provider, has my permission to transport my child, if necessary, when my child is in care. -----◆----- Physician's Name: _____ Address: _____ Phone #: _____	Child may be released to: Name: _____ Address: _____ Phone #: _____ Relationship: _____ -----◆----- Name: _____ Address: _____ Phone #: _____ Relationship: _____

The provisions outlined on this form have been worked out in consultation with me and have my approval.

Signature of Parent or Guardian _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

Is your child related to the person providing his/her child care? Yes No **If Yes, what is the relationship?** (Relationship= grandchild, niece, nephew, sibling, son or daughter by blood, adoption or marriage)

(This form must be kept on file for one year after the child is no longer enrolled in the child care home.)