

**A Shining Star Learning Center**  
Enrollment/Waiting List Application

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
\_\_\_\_\_ Social Sec. #: \_\_\_\_\_

**Parent/Guardian #1:**

**Parent/Guardian #2:**

Name: \_\_\_\_\_ Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
\_\_\_\_\_ \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Social Sec. #: \_\_\_\_\_ Social Sec. #: \_\_\_\_\_  
Driver's License #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
\_\_\_\_\_ \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Work Hours: \_\_\_\_\_ Work Hours: \_\_\_\_\_

**Requested Schedule:**

Please indicate the days you would like to enroll your child:

\_\_\_\_\_ Monday \_\_\_\_\_ Tuesday \_\_\_\_\_ Wednesday \_\_\_\_\_ Thursday \_\_\_\_\_ Friday

Please indicate your child's approximate Drop Off Time: \_\_\_\_\_  
Please indicate your child's approximate Pick Up Time: \_\_\_\_\_  
Requested Start Date: \_\_\_\_\_

**Siblings**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Emergency Contact #1**

Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Hours: \_\_\_\_\_

**Emergency Contact #2**

Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Hours: \_\_\_\_\_

**Medical Information**

Child's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Office Hours: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_ Insurance: \_\_\_\_\_

Allergies or Other Medical Conditions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Child's Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Office Hours: \_\_\_\_\_

Insurance: \_\_\_\_\_

**Authorized Pick Up People**

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_