



Bethesda Child Development Center  
 116 East Main Street  
 Middletown, Delaware 19709  
 (302) 378-8435 / (302) 378-7613 fax

**ENROLLMENT FORM (PAGE 1 OF 2)**

Date Child Started: \_\_\_\_\_ Date Child Ended: \_\_\_\_\_  
 Registration: \_\_\_\_\_  
 Arrival Time: \_\_\_\_\_ Depart Time: \_\_\_\_\_  
 Program: \_\_\_\_\_ Site/Room: \_\_\_\_\_  
 (For Office Use Only)

CHILD'S FULL NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ HOME PHONE # \_\_\_\_\_

STREET \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

PRIMARY GUARDIAN \_\_\_\_\_ RELATIONSHIP TO CHILD \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_ WORK HOURS \_\_\_\_\_

BUSINESS PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

E-MAIL \_\_\_\_\_

SECONDARY GUARDIAN \_\_\_\_\_ RELATIONSHIP TO CHILD \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_ WORK HOURS \_\_\_\_\_

BUSINESS PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

E-MAIL \_\_\_\_\_

\*Lives with  Mother  Father  Grandparents  Other \_\_\_\_\_ (Check all that apply)

\*Are there any custodial arrangements for this child?  Yes  No (If yes, copies of legal documentation must be submitted.)

**If not available in an emergency, notify:**

(Please note-Those listed here are considered authorized child release people and must be 18 years or older for emergency pick-up.)

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the Bethesda Child Development Center director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child as named above. I understand I will be financially responsible for the cost of such treatment.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_ Phone \_\_\_\_\_

**CHILD RELEASE- MUST BE 16 YEARS OLD OR OLDER TO PICK UP CHILDREN FROM BCDC PROGRAMS**

The following additional people are authorized to pick up my child from Bethesda Child Development Center:

	NAME	CELL	WORK
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**ALL DEPOSITS AND REGISTRATION FEES ARE NON-REFUNDABLE. ALL FORMS AND FEES NEED TO BE INTO THE OFFICE BY NOON ON WEDNESDAY TO BEGIN ON THE NEXT MONDAY.**

(CA \_\_\_\_\_/PC \_\_\_\_\_/AA \_\_\_\_\_/FM \_\_\_\_\_)

**HEALTH APPRAISAL**

Complete the following & give additional comments if needed:

CHILD'S MEDICATIONS \_\_\_\_\_

CHILD'S MEDICAL ALLERGIES \_\_\_\_\_

CHILD'S FOOD ALLERGIES \_\_\_\_\_

Additional Information about your child (includes, serious illness, accidents, operations, etc., with dates)

Does your child have a current Individualized Education Program (IEP) through Appoquinimink School District?

Yes     No

Does your child have a current Section 504 of the Rehabilitation Act plan?     Yes     No

What is your child's primary language? \_\_\_\_\_

Does your child have a secondary language? \_\_\_\_\_

Please share with BCDC any religious or cultural traditions your family observes or does not observe throughout the year: \_\_\_\_\_

**GUARDIAN SIGNED RELEASES**

- ▶ Photo Release: I hereby give my permission for my child to be photographed, videotaped and/or audio taped while engaging in BCDC activities. I hereby give my permission for these photographs, videos, and/or audio to be used as BCDC needs. I.E. Facebook, advertising, curriculum, in the community, etc.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

- ▶ Tadpoles: I acknowledge and give permission for BCDC to utilize the Tadpoles program with my child.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

- ▶ Transportation Release: I hereby give my permission for my child to be transported by BCDC.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**ALL CALL PHONE NUMBERS**

Please list below the two phone numbers you would like to be used for our All Call system.

1. \_\_\_\_\_ 2. \_\_\_\_\_