



The Coordinated Child Development Program, Inc.

ENROLLMENT FORM

If one or both parents are employees at Clifton Springs Hospital, and/or G.W. Lisk,

 * (only applies to OCP)

Site: _____

PARENT NAME(S): _____

ADDRESS: _____ COUNTY: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE # _____ (home) _____ (work) _____ (cell)

EMAIL ADDRESS: _____

NAME OF CHILD(REN) ENROLLED	SEX	DATE OF BIRTH	RACE*	Grade (if applicable)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

EMPLOYMENT INFORMATION: (please write out employer's name; do not use abbreviations)*

	Father	Mother
Names:	_____	_____
Employer:	_____	_____
Employer's Address:	_____	_____
	_____	_____
Occupation:	_____	_____

Beginning on (date) _____, my child(ren) will attend following days **M T W TH F**
 (check all days attending)

Complete the following where applicable

For Infants, Toddlers and Preschoolers: Times: from _____ to _____

For School Age: Before School After School Both

My Child will normally be eating: Breakfast Lunch Snack

Please Note: We request a 2 week written notice when leaving any of our programs

* Information on race and employment is needed for the United Way Beneficiary Report (your name will not be used)

Parent/Guardian Signature _____ Date _____

Review Section

_____	_____	_____	_____
Parent/Guardian Signature	Date	Parent/Guardian Signature	Date
_____	_____	_____	_____
Parent/Guardian Signature	Date	Parent/Guardian Signature	Date

Revised 04/10