WONDERSPRING
EARLY EDUCATION

Application/Enrollment Form

Center/School:	Grade as of September 2020:	Desired Start Date:	
Child's Name:	Gender:	Birth Date:	
Address Where Child Resides:	City:	State:	Zip:
Child Resides With: ☐ Both Parents ☐ Mother ☐ Father ☐ Other (Please Specify)________________________		Primary Language Spoken at Home:	
How did you hear about Wonderspring?:			

Parent/Guardian 1 Information

Name:	Home Phone Number:	Cell Phone Number:	
Email Address:	Employer/Workplace:		
Work Address:		Work Phone Number:	
Home Address:	City:	State:	Zip:

Parent/Guardian 2 Information

Name:	Home Phone Number:	Cell Phone Number:	
Email Address:	Employer/Workplace:		
Work Address:		Work Phone Number:	
Home Address:	City:	State:	Zip:

Please check the days needed for each program type. (Minimum of 3 days/week)

Before School Care Program (7:00 AM – 9:00 AM)	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday
After School Care Program (3:20 PM – 6:00 PM)	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday

Please briefly describe any special needs, disabilities, or allergies of your child. Continue on back if needed.

Application Fee: $25 per child at time of Application / Enrollment Fee: $50 per family at time of Enrollment
(Both Application and Enrollment Fees are Non-refundable)

Please be advised that completion of this application is not a guarantee of placement in our program. Once your application has been received,we will notify you if placement for your child is available.

Signature of Parent or Guardian: ________________________ Date: ____________

Signature of Center Administrator: ________________________ Date: ____________

EMERGENCY CONTACT PERSON(S) - Person(s) to whom child may be released other than the parents				
Name:	Home Phone Number:	Cell Phone Number:		
Address:	City:	State:	Zip:	Primary Language:
Name:	Home Phone Number:	Cell Phone Number:		
Address:	City:	State:	Zip:	Primary Language:
Name:	Home Phone Number:	Cell Phone Number:		
Address:	City:	State:	Zip:	Primary Language:

MEDICAL INFORMATION				
Name of child's Physician/Medical Care Provider:		Phone Number:		
Address:	City:	State:	Zip:	Primary Language:
Allergies (including medication reactions):				
Medical or Dietary Information Necessary in an Emergency Situation:				
Medication Special Conditions:				
Health Insurance Coverage for Child or Medical Assistance Benefits:				
Policy Number (required):	Date of Last Physical:			

PARENT'S SIGNATURE REQUIRED FOR EACH ITEM BELOW - Indicates Consent	
Photos/Videos:	Admin of Minor First-Aid Procedures/Obtaining Medical Care:
Walks and Trips:	Transportation by the Facility:

Signature of Parent or Guardian: ____ Date: ________________

PERIODIC REVIEW
Signature of Parent or Guardian: ____ Date: ________________

FEE INFORMATION (office copy only)		
Fee:	☐ Monthly / ☐ Weekly	Funding: ☐ Sub ☐ Pri ☐ Other
Escrow:		Days Enrolled: ☐ M ☐ T ☐ W ☐ TH ☐ F
Classroom:		