Kid Prints, Inc

210 SOUTH 5TH STREET
SUNDANCE, WY 82729
(307) 283-2682
KIDPRINTSINC@GMAIL.COM

PRESCHOOL ENROLLMENT FORM

Today's Date: _____ Date of Enrollment: _____

Child's Name: _____

Child's Nickname (if applicable): _____ Child's Date of Birth: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Parent/Legal Guardian #1 Name: _____ Relationship to Child: _____

Home Address (if different from above): _____

Employer: _____ Occupation: _____

Employer Address: _____

Work Phone: _____ Cell Phone: _____ Other Phone: _____

Email Address: _____

Parent/Legal Guardian #2 Name: _____ Relationship to Child: _____

Home Address (if different from above): _____

Employer: _____ Occupation: _____

Employer Address: _____

Work Phone: _____ Cell Phone: _____ Other Phone: _____

Email Address: _____

In order to receive electronic newsletters and other electronic communication please provide your email address.

MEDICAL INFORMATION

List any medical conditions of which Kid Prints, Inc. should be aware, including, but not limited to, frequent illnesses, injuries or hospitalizations: _____

_____

LIST ANY KNOWN ALLERGIES, INCLUDING FOOD AND MEDICATION ALLERGIES: _____

_____

_____

Does your child receive therapeutic services in a developmental center or school ☐ Yes ☐ No

If yes, please check which services:

☐ Occupational therapy ☐ Physical therapy ☐ Speech Therapy
☐ Behavior therapy ☐ Psychological/Counseling services

Communication: (check any that apply)

☐ Wears glasses ☐ Wears hearing aides ☐ Lip reads
☐ Uses light board or other adaptive device ☐ Uses sign language or hand signals

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EMERGENCY CONTACT INFORMATION

Child's Name: _____ Child's Date of Birth: _____ Sex: _____

Parent/Legal Guardian Name #1 _____ Phone: _____

Parent/Legal Guardian Name #2 _____ Phone: _____

In the event of an emergency, I hereby authorize Kid Prints, Inc. to contact the following person(s) if I cannot be contacted:

Emergency Contact Name #1 _____ Phone: _____

Emergency Contact Name #2 _____ Phone: _____

Emergency Contact Name #3 _____ Phone: _____

Emergency Contact Name #4 _____ Phone: _____

Health insurance information:

Company Name: _____

Company Address: _____

Name of Policy Holder: _____ Policy Number _____ Group: _____

AUTHORIZATION FOR MEDICAL TREATMENT

I authorize the hospital and attending physicians to submit claims to the above named company and hereby assign benefits directly to this company. I understand that I am financially responsible to providers of service for charges not covered by any insurance payments.

I, _____ hereby give permission to Kid Prints, Inc. to obtain medical or surgical care from a health care facility, physicians or dentists for my child, whose full name is _____ _____ and date of birth is _____ should the need arise. It is understood that a conscientious effort will be made to locate me before action will be taken. If this is not possible, treatment as deemed necessary by the physicians/dentists may be taken. I further hereby consent to transportation of the above named child to the nearest or most appropriate health care facility.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date