Samish Early Learning Center
1618 D. Ave Anacortes, WA
98221
(360) 588-8806

Samish ELC Enrollment Form

Please circle requested days of care:

Mon Tu Wed Th Fri

Times: _____ to _____

Child Information

Name (Last, First, MI)	DOB	Gender	Race	Language(s) spoken:
		□ M □ F		Primary: Secondary:

Parent or Guardian - All parents/guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any.

Relationship to Child	Name	DOB	Address - Home (Street, City)	Home/Cell Telephone No.	Name and Address: Place of Employment OR Where Reachable While Child is in Care	Telephone No.

Authorized Persons - Persons other than parents/guardians who are authorized to pick up the child. If no one, write "None".

Relationship to Child	Name	Address - Home (Street, City)	Home/Cell Telephone No.	Name and Address: Place of Employment OR Where Reachable While Child is in Care	Telephone No.

Emergency Contact - The person to be notified in an emergency when parents/guardians cannot be reached

Relationship to Child	Name	Address - Home (Street, City)	Home/Cell Telephone No.	Name and Address: Place of Employment OR Where Reachable While Child is in Care	Telephone No.
This person is authorized to pick up the child □ Y □ N					
This person is authorized to pick up the child □ Y □ N					

Physician or Medical Facility				
Name	Address (Street, City)	Telephone No.	Date of last exam	Does you child have a diagnosed disability? □ Y □ N If Y, on an IEP/IFSP? □ Y □ N

Dental Provider			
Name	Address (Street, City)	Telephone No.	Date of last exam

Does you child have allergies or reactions to food, medicines, insects, animals, or other substances? □ Yes □ No

If Yes… if the allergy has the potential to be severe, the child's healthcare provider must complete a medical statement and an allergy care plan must be completed. Your child will need the signed provider's statement BEFORE starting in the classroom.

Please describe your child's allergy, symptoms, and severity: _____

Does your child take medication on a regular basis? □ Yes □ No

If Yes… and the child requires dosage during care hours, you will need to complete our medication authorization form.

Does your childhave any life threatening medical conditions that requres an individual health plan? □ Yes □ No

Do you have any health or developmental concerns regarding your child? □ Yes □ No

Please describe your concerns, if any: _____

□ Yes □ No I give permission for my child to receive first aid treatment by qualified staff persons.

□ Yes □ No I give permission for my child to participate in field trips and other activities during operating hours with 24hr notice for transported trips. □ Transported □ Walking

□ Yes □ No I give permission for my child to be in a class photo or a photo of classroom activities/field trips that may be posted or printed and shared with other families, children, or staff.

□ Yes □ No I give permission for pictures of my child or family to be used by the program for training, newspaper articles, or promotional displays.

Signature - Parent or Guardian	Date Signed