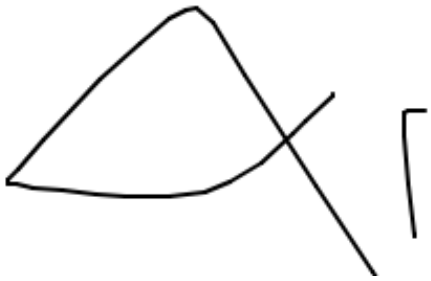
Infant Enrollment Packet

Childs' Name	
Date of Birth	
Age	
Gender	
If Yes, Where and for How long?	
Has your child been to a Preschool before?	
Monthly $Full Time 5 days	
Weekly $Full Time 5 days	
Monthly $Part Time 3 days	
Weekly $Part Time 3 days	
Monthly $ Part Time 2 days	
Weekly $Part Time 2 days	
Matrix(1)	
Matrix(1)(1)	
Request starting date	
How did you hear about us	
Mother's Name	
Social Security #	
DL #	
Address	
City	

	Monday	Tuesday	Wednesday	Thursday	Friday
Breakfast	✔		✔	✔	
Lunch		✔			
Snack					✔

Hours of Care (ex9-5)					

State	
Zip	
Email	
Home Phone	
Place of Employment	
Cell Phone	
Job Title	
Work Phone	
Marital Status	Select value
Custody Information	
Father's Name	
Social Security #father	
DL # father	
Address father	
City father	
State father	
Zip father	
Email father	
Home Phone father	
Place of Employment father	
Cell Phone father	
Job Title father	
Work Phone father	
Marital Status father	Select value
Custody Information father	
List any allergies your child has	
My child excels in	
My child needs help in	
Parent's evaluation of child's personality	
Does your child have any special needs/problems/fears?	
Additional information we should know about your child	
Date	
Parent/Guardian's Signature	

I/We the undersigned parents/legal guardian(s) of	
01. Pay tuition at a weekly rate of	
Monthly rate of	
15. I/ We, the undersigned parents of legal guardians of	
17. It is understood that as the parent(s) or legal guardian(s) of	
Dated	
AUTHORIZED REPRESENTATIVE OF KIDS ADVENTURE	
PARENT OR LEGAL GUARDIAN SIGNATURE	
Matrix01	

	Weekly or Monthly	Discount Type / Amount	Classroom	Total Tuition

Matrix02			
	In	Out	
Monday			

	Tuesday Wednesday Thursday Friday
Childs Name:	
Birth Date:	
Todays Date:	
1. Is your child on a special diet?	
If yes please specify:	
2. Does your child have any allergies?	
If yes, please list:	
3. Are there any foods your child should not eat for medical, personal, or religious reasons?	
4. Does your child use a bottle?	
What do you put in the bottle:	
5. My child uses a:	
6. Special likes and dislikes:	
7. Feeding Schedule	
8. Timeline to introduce solids and specific consistency offoods:	
1. What is your child's normal sleeping environment?	
2. What is your child's normal sleeping schedule and habits?	
3. What are your child's rolling abilities at this time?	
1. How many wet diapers a day approx.:	
2. How often does your child have a bowel movement:	
3. Any special comments or concerns in reference to diapering/toileting:	
4. Method preferred for toilet training:	
5. Specific equipment used and time line of use as directed/provided by parent as well as a timeline of	

introduction of appropriate clothing:	
Parents Name	
Date Toilet planing	
Center Representative:	
Daytime Phone# :	
Date Toilet planing 2	
Signature (Toilet planing)	
Child's Name:	
Classroom:	
Contact 1 Name	
Contact 1 Cell Phone #	
Contact 2 Name	
Contact 2 Cell Phone #	