

SAM'S KID SAFARI LEARNING ACADEMY

*Early Learning Center/Preschool/Before & After School Care
337-422-5227*

Enrollment Application

Location: __SUBDIVISION __PRESCHOOL __KINDERGARTEN __AFTERSCHOOL

Child's Full Name: _____

Birthdate: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____

Mother's Full Name: _____

Phone/Cell: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zipcode: _____

(only fill address if different from child---you can put SAME if it's the same)

Occupation: _____ Work Phone: _____

Name of Employer: _____

Business Address: _____ City: _____

Work Hours: _____

Father's Full Name: _____

Phone/Cell: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zipcode: _____

(Only fill address if different from child's---you can put SAME if it's the same)

Occupation: _____ Work Phone: _____

Name of Employer: _____

Business Address: _____ City: _____

Work Hours: _____

"Come Learn 1 or 2 Things With Us, Because A Person's A Person No Matter How Small!"



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Parent/Guardian with legal custody: _____

Other Household Members:

<u>Name(s)</u>	<u>Age</u>	<u>Relationship</u>
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Emergency Contacts

Primary Emergency Contact Other Than Parents/Guardians

Name: _____ Home #: _____ Cell#: _____

Relationship To Child: _____

Address: _____

Secondary Emergency Contact Other Than Parents/Guardians

Name: _____ Home #: _____ Cell#: _____

Relationship To Child: _____

Address: _____

Person's Authorized to Pick up My Child(Other Than Parents/Guardian)

<u>Name</u>	<u>Relationship To Child</u>
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Emergency Release:

Consent to Emergency First Aid & Transportation:

I hereby give permission to the staff at Sam's Kid Safari LLC to give emergency treatment to my child _____. I also give permission for my child to be transported by car or ambulance to an emergency center for treatment.

Consent to Medical Care and Treatment:

In the event that I cannot be contacted immediately, medical or surgical treatment can be administered to my child in the case of an accident or emergency, as prescribed by a treating physician.

Parent's Signature: _____

Date: _____

Emergency Information:

1. Child's Physician: _____
2. Preferred Hospital: _____
3. Regular Medicines: _____
4. Blood Type: _____
5. Any & All Allergies(food, meds, etc.)

6. Any special health conditions(seizures, migraines, ADD, ADHD, etc.): _____

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Expected Days and Times of Care Needed:

___ Monday Drop off Time: _____ Pickup Time: _____

___ Tuesday Drop Off Time: _____ Pickup Time: _____

___ Wed. Drop Off Time: _____ Pickup Time: _____

___ Thursday Drop Off Time: _____ Pickup Time: _____

___ Friday Drop Off Time: _____ Pickup Time: _____

___ Saturday Drop Off Time: _____ Pickup Time: _____

___ Sunday Drop Off Time: _____ Pickup Time: _____

- Are you currently approved for childcare assistance through the Louisiana Department of Education? _____
- If not, will you be applying to help offset your child's monthly tuition? _____
- Are you aware that there is a \$150 non-refundable registration fee per child that needs to be paid prior to your child starting? _____

Office Use Only:

___ Approved ___ Not Approved ___ Registration Fee Paid

Staff Signature: _____ Date: _____

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