HOPE BEGINNINGS
LEARNING CENTER

ENROLLMENT APPLICATION

(A $50 non-refundable registration fee must be returned with this form.)

Child's Name: ____

Preferred Name:______________________ Date of Birth:________________ Sex:_____

Allergies: ____

Program Option: ___3 yr old, Mon-Thurs, 8a-12p

*Must turn this age before Sept. 30, 2026 ___4 yr old, Mon-Thurs, 8a-12p

Extended Care Hours Needed (12:00pm-3:00pm): ___Yes ___No

*Additional cost

Parent's relationship to each other: ___Married ___Divorced ___Separated ___Single

Child lives with: ___Mother & Father ___Mother ___Father ___Other:__________________

Father: Name:________________________ Employer:____________________

Home Address:____

City:________________________ State:______________ Zip:______________

Phone:______________ Work Phone:______________ Mobile:______________

Email: ____

Mother: Name:________________________ Employer:____________________

Home Address:____

City:________________________ State:______________ Zip:______________

Phone:______________ Work Phone:______________ Mobile:______________

Email: ____

Family Religious Preference:__________________ Church Attending:__________________

Previous Preschools/Day Cares attended (include dates):____________________________

____

Emergency Contact: List someone who will be available to assume responsibility for your child in an emergency if parents can not be reached.

Name:________________________ Relationship to child:__________________

Home Address:____

City:________________________ State:______________ Zip:______________

Phone:______________ Work Phone:______________ Mobile:______________

Release of Child

I authorize that my child, __________________________, be released by Hope Beginnings Learning Center to the following persons in addition to those already listed on this form.

Name:____________________________________ Relationship to child:________________________
Home Address:____
City:_____________________________________ State:______________ Zip:____________________
Phone:____________________ Work Phone:____________________Mobile:_____________________

Name:____________________________________ Relationship to child:________________________
Home Address:____
City:_____________________________________ State:______________ Zip:____________________
Phone:____________________ Work Phone:____________________Mobile:_____________________

___ I authorize any photographs of my child, ____________________, may be used for promotional purposes by Hope Beginnings Learning Center.

___ I do **not** authorize any photographs of my child, ____________________, to be used for promotional purposes by Hope Beginnings Learning Center.

Emergency Medical Care

In the event that I cannot be reached to make arrangements for emergency medical attention for my child, I release Hope Beginnings Learning Center staff to take my child to an Emergency Room or to the following physician or his/her associates for care.

Doctor:___________________________________ Hospital:__________________________________
Address:____ Phone:_____________________
City:_________________________________ State:________________ Zip:______________________
Special Instructions:____
____

I give consent for any and all treatment deemed necessary by the attending physician. (Attach a photocopy of your insurance card)

____

________________________________ ______________________
(Signature of Parents/Guardians) (Date)