ENROLLMENT PACKET

Copy: Birth certificate ___ Shot records ___ Physical Exam record ___

Date of Enrollment:_____ First Day:_____ Last Day:_____

CHILD INFORMATION

First Name:_____ Last Name: _____

Gender: M____ F_____ Date of Birth:_____ Phone:_____

Physical Address:_____

Mailing Address:_____

PARENT INFORMATION

Mother

First Name: _____ Last Name_____

Physical Address:_____

Mailing Address:_____

Place of Employment:_____

Phone 1:_____ (home/cell) Phone 2:_____(work)

Email address:_____

Father

First Name: _____ Last Name_____

Physical Address:_____

Mailing Address:_____

Place of Employment:_____

Phone 1:_____ (home/cell) Phone 2:_____(home/cell)

Email address:_____

Primary custody of child (check all that apply): Mother_____ Father_____ Other_____

AUTHORIZED PICK-UP

1. Name:_____Relationship to child:_____
2. Name:_____Relationship to child:_____
3. Name:_____Relationship to child:_____
4. Name:_____Relationship to child:_____
5. Name:_____Relationship to child:_____

I give the above listed people the permission to pick up my child from Charlotte's Place

Parent Signature:_____Date:_____

EMERGENCY INFORMATION:

Please list any allergies:_____

Please list any medical conditions:_____

Special dietary requirements:_____

Receiving services from local agency: Y_____ N_____

If Yes, list agency:_____ Services Received:_____

IFSP/IEP in place: Y____ N____ Other plan in place:_____

Parent permission for above agency information to be released to Charlotte's Place: Y_____ N_____

Local Emergency Contact 1:

Name:_____ Phone:_____

Relationship to Child:_____

Local Emergency Contact 2:

Name:_____ Phone:_____

Relationship to Child:_____

Child's Primary Care Physician (PCP):

Name_____ Phone:_____

I give permission for Charlotte's Place to contact my PCP in event of an emergency: Y_____ N_____

I agree to ensure my child attends regularly scheduled well-child visits with PCP and will provide Charlotte's Place Preschool with a copy of updated medical information as available.
Parent Initial _____

Hospital Preference:

_____ Memorial Medical Center
Address: 2450 S Telshor Blvd
Las Cruces, NM 88011
Phone: (575) 522-8641

_____ Mountain View Regional Medical Center
Address: 4311 E. Lohman Ave.
Las Cruces, NM 88011
Phone: (575) 556-7600

I give permission for Charlotte's Place to transport my child in the event of an emergency: Y____ N____

I authorize medical personnel to provide medical treatment in the event of an emergency: Y____N_____

Parent Signature:_____Date:_____

TYPE OF ENROLLMENT

Full Time: _____

- $695 (below age 2) $595 (above age 2) + tax per month
- Child Care Assistance: Co-Pay $_____

Part Time: _____ (less than 4 hours per day or 2 days per week)

- $482.50 (below age 2) $382.50 (above age 2) + tax per month
- Child Care Assistance: Co-Pay $_____

Drop In: _____ (based on availability of space at time of need)

- $15 + tax per hour (due upon drop off)
- $35 (below age 2) $30 (above age 2) + tax per day (due upon drop off)

Other: _____

Registration fee: $75 per year (non-refundable, due date of enrollment and annually thereafter)

Payment due upon enrollment for first month, then on the 1st of the month or 1st and 15th of the month if paid half amount bi-monthly.

Late fee: $15+ tax per day late (begins 10 days after due date)

I would like to pay: monthly _____ bi-monthly_____

I would like to pay: credit card _____ (auto debit) check_____ cash_____

Credit/Debit Card:

Name on Card: _____

Card #:__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ Expiration Date: ____/_____

Security Code (back of card): __ __ __ Billing Zip Code __ __ __ __ __

(Credit card will be charged based on monthly schedule checked above)

_____ I agree to the above terms of enrollment at Charlotte's Place.

Parent Signature:_____ Date_____