ALL FORMS MUST BE COMPLETELY FILLED OUT IN ADVANCE BY PARENTS AND YOUR CHILD'S DOCTOR IN ORDER FOR YOUR CHILD TO START SCHOOL

QUALITY TIME LEARNING CENTER

Before & After Care Program

8101 Georgia Avenue
Silver Spring, MD 20910

Requested date for enrollment:

_____/_____/_____

Registration Application

Age: _____

Child's Name: First _____ M.I._____ Last _____ **D.O.B.** ___/___/___
Home Address: _____
_____
Gender: Male _____ Female _____

Mother/Guardian's Name: (circle) First _____ M.I._____ Last _____
Home Address: _____ **Home Phone:** ( )_____-_____
_____
Employed by: _____ **Occupation:** _____ **Work Hours:** _____
Work Address: _____
Work Phone:( )_____-_____ **Cell Phone:**( )_____-_____ **E-mail Address:** _____

Father/Guardian's Name: (circle) First _____ M.I._____ Last _____
Home Address: _____ **Home Phone:** ( )_____-_____
_____
Employed by: _____ **Occupation:** _____ **Work Hours:** _____
Work Address: _____
Work Phone:( )_____-_____ **Cell Phone:**( )_____-_____ **E-mail Address:** _____

Are parents divorced or separated: _____
With whom does the child reside?: _____ Who has legal custody?: _____
Language spoken at home?: _____ _____ _____
Brother's/Sister's: _____ _____ _____
Dates of Birth: ___ ___ ___ ___ ___ ___ ___ ___ ___
Mo. Day Yr. Mo. Day Yr. Mo. Day Yr.

List any existing medical conditions, allergies and/or special attention your child may require:

_____
_____

(For those emergencies requiring immediate attention, I understand and agree that my child will be taken to Holy Cross Hospital)

Parent's Signature: _____ **Date:** _____/_____/_____