

Teacher's Name: \_\_\_\_\_

**NOAH'S LANDING ENROLLMENT FORM**

Child's Full Name: \_\_\_\_\_

Preferred Nickname: \_\_\_\_\_

Parent /Guardian's Names: \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_ (Mom) \_\_\_\_\_ (Dad)

Phone (home) \_\_\_\_\_ (work-Mom) \_\_\_\_\_

(work-Dad) \_\_\_\_\_ (Cell/Mom) \_\_\_\_\_ (Cell/Dad) \_\_\_\_\_

E-Mail: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_ Age as of Sept. 30, 2016 \_\_\_\_\_

Siblings: \_\_\_\_\_ Age \_\_\_\_\_

\_\_\_\_\_ Age \_\_\_\_\_

\_\_\_\_\_ Age \_\_\_\_\_

Any other information that would enable us to better care for and support your child in your absence: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital Affiliation: \_\_\_\_\_

Insurance Information:

Company: \_\_\_\_\_

Policy and/or Group Number: \_\_\_\_\_

Allergies or any medical problems that should be brought to our attention: \_\_\_\_\_

Persons to notify in case of emergency when parent cannot be reached:

\_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

Please complete and sign medical release statement below:

*The Parent/Guardian authorizes immediate medical care and consents to the hospitalization of, the performance of necessary diagnostic tests upon, the use of surgery on, and/or the administration to drugs to his/her child or ward if an emergency occurs when he/she cannot be located immediately.*

\_\_\_\_\_ Date: \_\_\_\_\_

When the preschool is unable to get in touch with a parent or guardian and a staff member is able to assess the needs of my child, I give permission for the following over-the-counter medication to be given (circle yes or no):

Benadryl elixir (Diphenhydramine)	Yes	No
Antibiotic ointment (Neosporin)	Yes	No
Benadryl ointment	Yes	No

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Parent/Guardian Signature