



Stepping Stones Discovery & Development Center

A Step Ahead !

Child's Name: _____	Child's Birth date: _____ Sex M F
Home Phone#: _____	Enrollment Date: _____
Mother's name: _____	Mother's Cell #: _____
Father's name: _____	Father's Cell #: _____
Mother's Address: _____	City: _____
Mother's Employer: _____	Mother's work #: _____
Father's Address (if different): _____	City: _____
_____	Father's work #: _____
Father's Employer: _____	

Weekly Care Schedule	Medical Contacts
Start Date: _____	Child's Doctor: _____
Hours	Address: _____
Monday: _____	Phone #: _____
Tuesday: _____	Child's Dentist: _____
Wednesday: _____	Address: _____
Thursday: _____	Phone #: _____
Friday: _____	

Emergency Contacts	Authorized Pick-up
Name: _____	Name: _____
Address: _____	Address: _____
Phone #: _____	Phone #: _____
Relationship: _____	Relationship: _____
Is this person authorized to make medical decisions for your child if you cannot be reached? Y N	Name: _____
Name: _____	Address: _____
Address: _____	Phone #: _____
Phone #: _____	Relationship: _____
Relationship: _____	Note: Any person unfamiliar to staff will be required to show a picture ID.
Is this person authorized to make medical decisions for your child if you cannot be reached? Y N	

Limitations
Please indicate any limitations, restrictions, or concerns you may have for your child (ie. Allergies, medications, medical conditions, ect.) _____

I authorize Stepping Stones Discovery & Development Center Staff to obtain emergency medical treatment for my child should the need arise. I agree to assume all financial responsibility that may be required for treatment. To the best of my knowledge the information provided above is accurate.	
Parent / Guardian Signature: _____	Date: _____

For Office Use Only

Weekly Tuition:\$ _____	Registration Fee Paid	Y	N
L&M Staff: _____	Deposit	Y	N
Military 10% : _____	Physical/Imm.	Y	N
CEA 10% : _____	Registration Froms	Y	N
Multiple Family 10% : _____			
Tuition Express 5% _____			
Care for Kids: _____			
DSS: _____			