YEZ
YOUTH EMPOWERMENT ZONE
1002 Fay St. Columbia, MO 65201 Ph: 573-256-1896 Fax: 573-256-1882

INSPIRING ACADEMY
CHILD CARE ENROLLMENT FORM

DATE:

CHILD'S INFORMATION:

CHILD'S NAME:	GENDER: ☐ FEMALE ☐ MALE
CHILD'S AGE:	BIRTHDAY:
SCHOOL ATTENDING:	
CHILD LIVES WITH: ☐ MOM ☐ DAD ☐ MOM & DAD ☐ GUARDIAN	

MOTHER/GUARDIAN INFORMATION:

MOTHER'S OR GUARDIAN'S NAME:		CELL PHONE:
HOME PHONE:		WORK PHONE:
STREET ADDRESS:		
CITY:	STATE:	ZIP:
EMAIL ADDRESS:		
EMPLOYER'S NAME:		

FATHER'S INFORMATION:

FATHER'S NAME:		CELL PHONE:
HOME PHONE:		WORK PHONE:
STREET ADDRESS:		
CITY:	STATE:	ZIP:
EMAIL ADDRESS:		
EMPLOYER'S NAME:		

EMERGENCY CONTACT INFORMATION:

NAME:	RELATIONSHIP TO CHILD:	EMAIL:
CELL PHONE:	HOME PHONE:	WORK PHONE:
STREET ADDRESS:		
CITY:	STATE:	ZIP:
EMPLOYER'S NAME:		

ADDITIONAL CHILDREN:

CHILD'S NAME:	GENDER: ☐ FEMALE ☐ MALE
CHILD'S AGE:	BIRTHDAY:
SCHOOL ATTENDING:	
CHILD LIVES WITH: ☐ MOM ☐ DAD ☐ MOM & DAD ☐ GUARDIAN	

CHILD'S NAME:	GENDER: ☐ FEMALE ☐ MALE
CHILD'S AGE:	BIRTHDAY:
SCHOOL ATTENDING:	
CHILD LIVES WITH: ☐ MOM ☐ DAD ☐ MOM & DAD ☐ GUARDIAN	

CHILD'S NAME:	GENDER: ☐ FEMALE ☐ MALE
CHILD'S AGE:	BIRTHDAY:
SCHOOL ATTENDING:	
CHILD LIVES WITH: ☐ MOM ☐ DAD ☐ MOM & DAD ☐ GUARDIAN	

YOUR CHILD/CHILDREN'S HEALTH: A copy of your child/children's immunizations will be needed.

DOCTOR'S NAME:	DOCTOR'S PHONE:
DENTISTS' NAME:	DENTISTS' PHONE:
DOES YOUR CHILD HAVE ANY KNOWN ALLERGIES?	
ARE YOUR CHILD'S IMMUNIZATIONS UP TO DATE? ☐ YES ☐ NO	DOES YOUR CHILD HAVE ASTHMA? ☐ YES ☐ NO
DOES YOUR CHILD HAVE ANY MEDICAL CONDITIONS WE SHOULD BE AWARE OF? IF YES, PLEASE EXPLAIN:	
DOES YOUR CHILD HAVE ANY SPEECH, VISUAL OR HEARING PROBLEMS? IF YES, PLEASE EXPLAIN:	

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I understand that I will be notified at once in case of an emergency with my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice.

If I cannot be reached to make necessary arrangements, or in a critical emergency requiring medical care, I authorize **THE YOUTH EMPOWERMENT ZONE INSPIRING ACADEMY** to provide care. I understand all expenses related to such care are my responsibility.

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Parent/Guardian Signature