Montgomery Early Learning Centers

Visit us at **melc.org**

MELC USE ONLY:

Received By: _____ New: ☐ Change: ☐ Termination: ☐

Date Received: _____ Date Effective: _____

EARLY CHILDHOOD APPLICATION/ENROLLMENT FORM

Center:	Center Number:	Desired Start Date:	
Child's Name:	Gender:	Birth Date:	
Address Where Child Resides: Street:	City:	State:	Zip:
Child Resides With: ☐ Both Parents ☐ Mother ☐ Father ☐ Other (Please Specify)_____		Primary Language Spoken at Home:	

Parent/Guardian 1 Information

Name:	Home Phone Number:	Cell Phone Number:	
Email Address:	Employer/Workplace:		
Work Address:		Work Phone Number:	
Home Address: Street:	City:	State:	Zip:

Parent/Guardian 2 Information

Name:	Home Phone Number:	Cell Phone Number:	
Email Address:	Employer/Workplace:		
Work Address:		Work Phone Number:	
Home Address: Street:	City:	State:	Zip:

Please check the days of care needed (Min. of 3 days a week) & indicate AM or PM hours by filling in the times:

DAY:	FROM:	TO:
☐ Monday		
☐ Tuesday		
☐ Wednesday		
☐ Thursday		
☐ Friday		

Daily Expected Food Service

☐ Breakfast ☐ Lunch ☐ PM Snack

Is this child school age? ☐ Yes ☐ No

If yes, will additional meals be provided when school is not in session? ☐ Yes ☐ No

If yes, specify the meal:
☐ Breakfast ☐ Lunch ☐ PM Snack

Please briefly describe any special needs, disabilities, or allergies of your child. (Continue on back if needed)

Application Fee: **$25 per child** at time of Application // Enrollment Fee: **$50 per family** at time of Enrollment
(Both Application and Enrollment Fees are Non-refundable)

Please be advised that completion of this application is not a guarantee of placement in our program.
Once your application has been received, we will notify you if placement for your child is available.

Signature of Parent or Guardian: _____ **Date:** _____

Signature of Center Administrator: _____ **Date:** _____

EMERGENCY CONTACT PERSON(S) - Person(s) to whom child may be released other than the parents				
Name:	Home Phone Number:	Cell Phone Number:		
Address:	City:	State:	Zip:	Primary Language:
Name:	Home Phone Number:	Cell Phone Number:		
Address:	City:	State:	Zip:	Primary Language:
Name:	Home Phone Number:	Cell Phone Number:		
Address:	City:	State:	Zip:	Primary Language:

MEDICAL INFORMATION				
Name of child's Physician/Medical Care Provider:		Phone Number:		
Address:	City:	State:	Zip:	Primary Language:
Allergies (including medication reactions):				
Medical or Dietary Information Necessary in an Emergency Situation:				
Medication Special Conditions:				
Health Insurance Coverage for Child or Medical Assistance Benefits:				
Policy Number (required):	Date of Last Physical:			

PARENT'S SIGNATURE REQUIRED FOR EACH ITEM BELOW - Indicates Consent	
Photos/Videos:	Admin of Minor First-Aid Procedures/Obtaining Medical Care:
Walks and Trips:	Transportation by the Facility:

This child care facility participates in the Child and Adult Care Food Program and uses an FSMC/Vendor. In order to receive federal funds, representatives of the sponsoring organization or the State Agency may contact you to verify your child's participation.
Please indicate what time and method of contact you prefer:

Time: ☐ Day ☐ Evening

Method: ☐ Letter ☐ Phone (Home) ☐ Phone (Work)

Signature of Parent or Guardian: _____ **Date:** _____

PERIODIC REVIEW

Signature of Parent or Guardian: _____ **Date:** _____

MELC is an equal opportunity care provider. All meals served to children under the Child and Adult Care Food Program are served at no separate charge regardless of race, color, national origin, sex, age, or disability. There is no discrimination in admission policy, meal service, or the use of facilities. Any complaints of discrimination should be submitted in writing within 180 days of the incident to the USDA, Director, Office of Civil Rights, Washington, D.C. 20250

FEE INFORMATION (office copy only)		
Fee:	☐ Monthly / ☐ Weekly	Funding: ☐ Sub ☐ Pri ☐ Other _____
Escrow:		CACFP: ☐ Free ☐ Reduced ☐ Paid _____
Classroom:		Days Enrolled: ☐ M ☐ T ☐ W ☐ TH ☐ F