

**EASTERN HILLS EDUCATIONAL BUILDING  
CHILD DEVELOPMENT CENTER  
4132 MT. CARMEL-TOBASCO RD.  
CINCINNATI, OHIO 45255  
513-528-1166**

**APPLICATION FOR ADMISSION**

CHILD'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_ CELL PHONE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ ZIP \_\_\_\_\_ HOME PHONE \_\_\_\_\_

EMPLOY NAME & ADD \_\_\_\_\_ ZIP \_\_\_\_\_ WORK PHONE \_\_\_\_\_

FATHER'S NAME \_\_\_\_\_ CELL PHONE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ ZIP \_\_\_\_\_ HOME PHONE \_\_\_\_\_

EMPLOY NAME & ADD \_\_\_\_\_ ZIP \_\_\_\_\_ WORK PHONE \_\_\_\_\_

If someone other than parent or custodian pays tuition, provide name, address, home and work phone numbers:

\_\_\_\_\_

If child lives with a custodian, provide name, address, home and work phone numbers:

\_\_\_\_\_

**NAMES OF PERSONS OTHER THAN PARENTS FOR EMERGENCY CONTACT AND RELEASE:**

Name & Relationship \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name & Relationship \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name & Relationship \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Child's Physician \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Child's Dentist \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

**UNDERSTANDING**

I HAVE RECEIVED, READ AND AGREE TO ABIDE BY THE PARENT'S POLICY MANUAL PROCEDURES.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**EMERGENCY MEDICAL AUTHORIZATION**

**IF A PARENT DESIRES NOT TO SIGN THIS CONSENT, THEIR CHILD WILL NOT BE ENROLLED.** In the event reasonable attempts to contact me, my spouse or the forgoing persons, have been unsuccessful, I hereby give my consent for the administration of any treatment or medication to my child deemed necessary by my child's physician/dentist or, in the event the designated practitioner is not available, another licensed physician/dentist, and the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two licensed physicians concur in the necessity for such surgery and such concurrence is obtained prior to the performance of such surgery.

**SIGNATURE SIGNIFIES AGREEMENT AND CONFIRMS THE AUTHORIZATION.**

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

APPROXIMATE STARTING DATE \_\_\_\_\_

APPROXIMATE STARTING TIME \_\_\_\_\_

APPROXIMATE DEPARTURE TIME \_\_\_\_\_

CLASS \_\_\_\_\_

PROGRAM \_\_\_\_\_

RATE \_\_\_\_\_

APPT. DATE \_\_\_\_\_

REGISTRATION \_\_\_\_\_

INSURANCE \_\_\_\_\_