Y's World of Learning Child Care Center

Brainerd Family YMCA • 602 Oak Street • Brainerd MN 56401 • 218-829-4767

Child's Information:

Child's First Name____________________ Middle Initial ____ Last Name _________________ Birthdate __________

Gender M F Child resides with . Mother . Father . Both . Other ____________________

Does your child have allergies? Yes No If yes, please explain: ____________________________________

Is your child on medication? Yes No If yes, please explain: ____________________________________

Does your child nap? Yes No Usual Time:__________________________________

What is your child's favorite activity? ______________________________________

What is your child's favorite toy? ____

The Brainerd Family YMCA has my permission for this child to be photographed/videotaped and/or interviewed for promotional purposes. Yes No Initials______

Enrollment Needs:

Hours: Full-Time Part Time **Days of The Week:** Monday Tuesday Wednesday Thursday Friday

Requested Begin Date: ______________________ **Approximate hours needed**:_________________

Payment Method: Monthly Bank-Draft Bi-Weekly Payments

Will child-care assistance be involved? Yes No If so, what county? ________________________

Parent Information:

#1 Parent/Guardian's First Name_________________________ Middle Initial ___ Last Name_____________________

Address____ City_____________________ State______Zip___________

Home Phone (____)______________ E-mail ______________________________________

Parent/Guardian's Work Phone (____)_____________________ Cell Phone/Pager (____)_________________________

#2 Parent/Guardian's First Name_________________________ Middle Initial ___ Last Name_____________________

Address____ City_____________________ State______Zip___________

Home Phone (____)______________ E-mail ______________________________________

Parent/Guardian's Work Phone (____)_____________________ Cell Phone/Pager (____)_________________________

EMERGENCY CONTACTS AND PICK-UP AUTHORIZATION - The following people should be contacted in case of emergency, only if parent or guardian cannot be reached AND are authorized to pick up the child:

1. Name___________________________________ Relationship to child_______________________________________
   Phone: Day (____)_____________ Cell (____) _______________ Address: _______________________ Zip:_______

2. Name____________________________________ Relationship to child_____________________________________
   Phone: Day (_____)____________ Cell (_____) _____________ Address: _______________________ Zip:______

Family Doctor _________________________ Phone (____) _______________ Address __________________________

Family Dentist _________________________ Phone (_____) _______________ Address _________________________

Do you carry family medical/hospital insurance? . Yes . No Carrier _____________Policy/Group #_______________

Date Completed_______________	Registration Fee Pd. ___________
YMCA Member? YES NO	Check #_________