



New Discoveries Child Care Center

Brainerd Family YMCA • 602 Oak Street • Brainerd MN 56401 • 218-829-4767 fax 218 829-4768

Child's Information:

Child's First Name _____ Middle Initial ____ Last Name _____ Birthdate _____

Nick name if uses one _____

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 _____

I give permission to allow staff to apply sunscreen as needed. Sign _____

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? <input type="checkbox"/> YES <input type="checkbox"/> NO	Check # _____