Children of Destiny Learning Academy

6030 N. W. 21st Avenue
Miami, Florida 33142

Enrollment Application

Application Date_____________________________________ Date of Enrollment________________________________

Student Information: Social Security#_________________________________ Date of Birth____________ Sex___

Full Name____
Last First Middle

Child's Home Address ____
Address Apt# City

_____________________________________ _______________________________
State Zip Code Home Phone

Family Information: Child Lives With ____

Mother's Name______________________________

Mother's Social Security# _____________________

Nationality____________ Country_______________

Email Address_______________________________

Address_____________________________________
If different from child's Apt#

____
City State Zip Code

Home Phone_______________________________
If different from child's

Employer__________________________________

Occupation________________________________

Address____________________________________
Suite#

____
City State Zip Code

Work Phone_________________ /Cell__________

Father's Name _____________________________

Father's Social Security#_____________________

Nationality____________ Country______________

Email Address_____________________________

Address___________________________________
If different from child's Apt#

____
City State Zip Code

Home Phone_______________________________
If different from child's

Employer__________________________________

Occupation_________________________________

Address____________________________________
Suite#

____
City State Zip Code

Work Phone_______________ /Cell___________

Who has custody? Mother 0 Father 0 Both 0 Other _____________

Child lives with: Mother 0 Father 0 Both 0 Other_____________

Medical Information:

I hereby grant permission for the staff of this facility to contact the following medical personnel to obtain emergency medical care if warranted. I hereby give permission to provide first aid care for my child. In the event I cannot be reached, I hereby authorize Children of Destiny Learning Academy, Inc. or their designated representative to transport my child to the nearest emergency room or any other that I designate, and I hereby grant my consent for the hospital and its medical staff to provide my child with emergency medical treatment which a physician deems necessary. If I have not specified any hospital below, my child will be taken to and cared for at the nearest hospital.

Child's Physician or Clinic Name (Child's Primary Health Source): ______________________________

Adress____

Phone

Hospital Preference____

I accept responsibility for any necessary medical expenses incurred in the medical treatment of my child,

which is not covered by the following: Health Insurance Company: ___________________________

ID# ___________________________________ Group# ________________________________

Name of Policy Holder _____________________ Relationship to Child _____________________

____

Please list allergies, special medical or dietary needs, or other areas of concern:

____

My child is currently on medication(s) prescribed for <u>long-term</u> continuous use:

____

Describe past serious illnesses or hospitalization, with dates: ____________________________________

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Additional information

Was your child premature? □Yes, Born at ___ weeks □No With language(s) does your child speak?__________

If your child doesn't speak yet, what language(s) does your child understand? ____________________________

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In order to assist us on providing the best possible service, please answer the following questions.

How did you hear about us? ____

If a friend or relative recommended us, may we have their name? We provide an incentive. __________________________

What convinced you to enroll your child at our preschool? ____

What school did your child last attend and why did you withdraw your child last attend and why did you withdraw your child? ____