

Office Use Only

REG PD CASH/CHECK #: _____ PICK-UP CARDS: _____

The Children's Country Place
3080 South Route 9, Seaville, NJ 08230
Phone: (609) 624-8624 Fax: (609) 624-3624
www.childrensplacecmc.com



CHILD'S NAME: _____
DATE OF BIRTH: _____ AGE: _____ GRADE (at time of enrollment): _____ SEX: _____

Mother's Name: _____ Home Phone: _____
Address: _____ Cell Phone: _____
City: _____ State: _____ Zip: _____
Place of Employment: _____ Work Phone: _____
E-mail address: _____

Father's Name: _____ Home Phone: _____
Address: _____ Cell Phone: _____
City: _____ State: _____ Zip: _____
Place of Employment: _____ Work Phone: _____
E-mail address: _____

Emergency Contact Person (other than parents) _____
Relationship: _____ Contact number: _____
Names of people who will have pick-up cards: _____

SPECIAL NEEDS/CONCERNS _____

Any Parent Restrictions? YES _____ (if yes, please attach documentation) NO _____

Does your child have any Special Needs / Allergies _____

Pediatrician's Name / Number: _____

Are You Aware of our Sick Policy? YES _____ NO _____

Who will care for your child when they are sick? _____

I give my permission to take photos, post to the website, and use for news articles. YES _____ NO _____

How did you hear about our School? _____

Type of program desired: (circle those which apply)

BEFORE CARE AFTER CARE BOTH

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY

Hours of Care: 7:00am – 8:30am 3:30pm – 4:30pm 3:30pm – 5:00pm

The above information is completed to the best of my knowledge. I will take full responsibility for informing the school of any changes and for any and all payments due for my child/children. I understand that two weeks notice is required for any changes. A late fee of \$35 will be charged if tuition is not received within one week of the due date, and no refunds will be issued for days missed.

Parent Signature

Date

Start Date