CROSSROADS EARLY LEARNING CENTER

114 Old Stage Road
East Brunswick, NJ 08816
732.251.3221 *fax* 732.723.9026

ADMISSION INFORMATION

Child's Name: ______________________ **Date of Birth**: ____________

Preferred Name: ______________________ ❑ Boy ❑ Girl

Child lives with ❑ Mother ❑ Father ❑ Both Parents ❑ Other ____________

Entry Code ____________

MOTHER

Name ______________________ E-Mail Address ______________________

Address ______________________ Home Phone ____________

City / State ______________________ Zip ________ Cell Phone ____________

Cell Phone Carrier: ____________

Employer
- Name ______________________
- Address ______________________
- City/State ______________________ Zip ________
- Work Phone ______________________ Ext ________
- Profession ______________________

FATHER

Name ______________________ E-Mail Address ______________________

Address ______________________ Home Phone ____________

City/State ______________________ Zip ________ Cell Phone ____________

Cell Phone Carrier: ____________

Employer
- Name ______________________
- Address ______________________
- City/State ______________________ Zip ________
- Work Phone ______________________ Ext ________
- Profession ______________________

OTHERS AUTHORIZED TO PICK UP CHILD

Name ______________________________

Phone # ______________________________

Address ______________________________

City/State/Zip ______________________________

Name ______________________________

Phone # ______________________________

Address ______________________________

City/State/Zip ______________________________

Name ______________________________

Phone # ______________________________

Address ______________________________

City/State/Zip______________________________

Name ______________________________

Phone # ______________________________

Address ______________________________

City/State/Zip ______________________________

AUTHORIZED PERSONS WHO MAY SIGN FOR EMERGENCY TREATMENT

Name ______________________________

Phone # ______________________________

Address ______________________________

City/State/Zip ______________________________

Name ______________________________

Phone # ______________________________

Address ______________________________

City/State/Zip ______________________________

Name ______________________________

Phone # ______________________________

Address ______________________________

City/State/Zip ______________________________

LIST ALL ALLERGIES

1. ______________________________
2. ______________________________
3. ______________________________

LIST ALL MEDICAL CONDITIONS

1. ______________________________
2. ______________________________
3. ______________________________

MEDICAL INSURANCE______________________________

Insured's Name______________________________

Policy Number ______________________________

Group Number______________________________

Hospital Preference ______________________________

Child's Physician ______________________________

Physician's Address ______________________________

City/State/Zip ______________________________

Physician's Phone # ______________________________

Child's Dentist ______________________________

Dentist's Address ______________________________

City/State/Zip ______________________________

Dentist's Phone # ______________________________