

Willow Bend Learning Center

3900 W. Park Blvd; Plano, TX 75075

Ph: 972-867-1871; Fax: 972-964-7097; E-Mail: willowbendlc@aol.com; Director: Roonu Rizavi

ENROLLMENT INFORMATION

Child's Name:	DOB:	M/F
Child's Address:	City, State, Zip:	
Home Phone #: ()	Admitted on:	Withdrawn on:
Mother's Name:	Occupation:	
Work Address:	E-mail:	
Work Phone: ()	Mobile: ()	
Mom's Driver's License #:	Mom's Social Security #:	
Father's Name:	Occupation:	
Work Address:	E-Mail:	
Work Phone: ()	Mobile: ()	
Dad's Driver's License #	Dad's Social Security #	
Persons to contact in emergency (if cannot reach parents):		
1. Name:	Work phone:	Mobile:
Address:		Relationship:
2. Name:	Work phone:	Mobile:
Address:		Relationship:
I hereby authorize WBLC to allow my child to leave the facility ONLY with the following persons, or his regular carpool driver(s). My child will not leave with any other person without written permission:		
1. Name:		Ph:
2. Name:		Ph:

List any problems that your child may have, such as allergies, existing illness, previous serious illness, injuries during the past 12 months, any long term medication prescribed, or any other conditions that the staff should be aware of:

AUTHORIZATIONS: (Check all that apply)

1. **TRANSPORTATION:** I hereby give do not give >>permission for my child to be transported and supervised by WBLC's staff: for emergency care on field trips to and from school

2. **FIELD TRIPS:** I hereby give do not give >>permission for my child to participate in Field Trips

3. **WATER ACTIVITIES:** I hereby give do not give >>permission for my child to participate in water activities in swimming pools other water activities

4. **OPERATIONAL POLICIES:** I acknowledge receipt of the operational policies, including those for discipline and guidance.

5. **EMERGENCY EVACUATION:** I hereby give >>permission to take my child to the *Emergency Evacuation Site at Chabad Center of Plano, at 3904 Park Blvd.; Plano, TX 75075*

6. **EMERGENCY MEDICAL ATTENTION:** If I cannot be reached to make arrangements for emergency medical care, I authorize WBLC to secure any and all necessary emergency medical care for my child

Name of Physician: _____ Ph: _____

Address of Physician: _____

Name of Emergency Medical Care Facility: _____ Ph: _____

Address of Medical Facility: _____

Parent/Guardian's Signature _____

Date _____

For **SCHOOL AGE CHILDREN** only:

My child attends the following school: _____ Ph: _____

His/her immunization is on file at the school and all required immunizations and/or TB tests are current.

Vision and Hearing screening records are current and on file at the school

My child has permission to be transported to and from school by the WBLC van and staff

Parent/Guardian's Signature _____

Date _____