



Fax: 501-835-3582
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DREAM

PRE-KINDERGARTEN ENROLLMENT APPLICATION

Ages 3-5

CHILD INFORMATION

Child Name:		
Date of birth:	Male <input type="checkbox"/> Female <input type="checkbox"/>	Phone:
Age:	Race:	Special Needs:
Current address:		
City:	State:	ZIP Code:
Has Your Attended Pre-K before? Yes <input type="checkbox"/> No <input type="checkbox"/> Where?		

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name:		
Address:		
City:	State:	ZIP Code:
Email:	Phone:	

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:	
Relationship to Child:	Phone:
Physician Name:	Phone:
Preferred Hospital:	
Allergies:	

PICK-UP AUTHORIZATION

Name	Phone

CONSENT TO EMERGENCY FIRST AID & TRANSPORTATION

In the event of an emergency, I hereby give permission for my child to be given emergency treatment by a staff member at DREAM. I also give permission for my child to be transported by ambulance to an emergency center for treatment, and agree to hold DREAM and its employees harmless.

Parent Signature:	Date:
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CONSENT TO MEDICAL TREATMENT

In the event that I cannot be contacted immediately, medical treatment can be administered to my child in the case of an accident or emergency, as prescribed by a treating physician, and hold DREAM and its employees harmless.

Parent Signature:	Date:
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MEDIA RELEASE

With my signature below, I give permission for DREAM to photograph my child for the purpose program advertisement for the DREAM website and program bulletins recruitment, newsletters and media that promote student and program success.

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

Parent Signature:	Date:
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