JAMES & SUZANNE MCCORMICK
Montessori
Child Care Center
AFFILIATED WITH SWEDISH COVENANT HOSPITAL

Days Desired:
Mon. Tues. Wed. Thurs. Fri.

Hours Desired:
_____To _____

Room Assignment:_____
Starting Date:_____
App. Fee: ch #:_____
Date:_____
Receipt #:_____
Amount:_____
Discharge Date:_____

McCormick Child Care Center
Application for Enrollment

_____ _____ _____
Name of Child (Last) (First) (Date of Birth) (Sex)

_____
Address (Street) (City) (State) (Zip Code)

Has the child attended school before? ☐ YES ☐ NO

Name of School:_____ Dates of Attendance:_____

_____ _____
Parent's Name Parent's Date of Birth

_____ (_____)_____
Address (City) (Zip Code) Phone Number

_____ _____
Occupation Place of Employment (if SCH, specify Department)

_____ (_____)_____
Address of Employer Phone Number (if SCH, specify extension)

_____ Marital Status: ☐ Single ☐ Married
Hours Worked ☐ Separated ☐ Divorced

_____ _____
Religion (optional) Nationality (optional)

Co- Parent's Name

Co- Parent's Date of Birth

Address (City) (Zip Code)

(_____)_____
Phone Number

Occupation

Place of Employment

Address of Employer

(_____)_____
Phone Number

Hours Worked

Marital Status: □ Single □ Married
□ Separated □ Divorced

Religion (optional)

Nationality (optional)

Family email: _____

If parents are separated or divorced, please provide the name of the parent who has legal custody of the child: _____

Please provide the names and the birth dates of all siblings:

1. _____ _____
Name Date of Birth

2. _____ _____
Name Date of Birth

3. _____ _____
Name Date of Birth

4. _____ _____
Name Date of Birth

_____ _____
Signature of Parent Date