

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: _____

Mother's Name

Mother'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)

Hours Worked

Marital Status: Single Married
 Separated Divorced

Religion (optional)

Nationality (optional)

Father's Name

Father'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