New Discoveries Child Care Center

Brainerd Family YMCA • 602 Oak Street • Brainerd MN 56401 • 218 829 4767 fax 218 829 4768

Child's Information:

Child's First Name_____ Middle Initial ____ Last Name _____ Birthdate _____
Nick name if uses one_____
Gender □M □F Child resides with □Mother □Father □Both □Other _____

Does your child have allergies? □Yes □No If yes, please explain: _____
Is your child on medication? □Yes □No If yes, please explain: _____
Does your child nap? □Yes □No Usual Time:_____
What is your child's favorite activity? _____
What is your child's favorite toy? _____

The Brainerd Family YMCA has my permission for this child to be photographed/videotaped and/or interviewed for promotional purposes. □Yes □No Initials_____
I give permission to allow staff to apply sunscreen as needed. Sign_____

Enrollment Needs:

Hours: □Full-Time □Part Time **Days of The Week:** □Monday □Tuesday □Wednesday □Thursday □Friday
Requested Begin Date: _____ **Approximate hours needed**:_____

Payment Method: □Monthly Bank-Draft □Bi-Weekly Payments
Will child-care assistance be involved? □Yes □No If so, what county? _____

Parent Information:

#1 Parent/Guardian's First Name_____ Middle Initial ___ Last Name_____
Address_____ City_____ State_____Zip_____
Home Phone (____)_____ E-mail _____
Parent/Guardian's Work Phone (____)_____ Cell Phone/Pager (____)_____

#2 Parent/Guardian's First Name_____ Middle Initial ___ Last Name_____
Address_____ City_____ State_____Zip_____
Home Phone (____)_____ E-mail _____
Parent/Guardian's Work Phone (____)_____ Cell Phone/Pager (____)_____

EMERGENCY CONTACTS AND PICK-UP AUTHORIZATION - The following people should be contacted in case of emergency, only if parent or guardian cannot be reached AND are authorized to pick up the child:

1. Name_____ Relationship to child_____
Phone: Day (____)_____ Cell (____) _____ Address: _____ Zip:_____

2. Name_____ Relationship to child_____
Phone: Day (_____)_____ Cell (_____) _____ Address: _____ Zip:_____

Family Doctor _____ Phone (____) _____ Address _____
Family Dentist _____ Phone (_____) _____ Address _____

Do you carry family medical/hospital insurance? □Yes □No Carrier _____Policy/Group #_____

Date Completed_____	Registration Fee Pd. _____
YMCA Member? ☐ES ☐O	Check #_____