



Linda's Family Child Care

610 Ransom Court, Odenton, MD 21113

www.lindaschildcare.net

Intent to Enroll

Child's Name _____

Nickname (if any) _____ Date of Birth _____

Child lives with _____

Child's Primary Address _____

Child's Primary Phone _____ Parent Email: _____

Parent/Guardian Information – please list each parent/guardian

Name:	Cell:
Address:	Text <input type="radio"/> Yes <input type="radio"/> No
Email:	Home:
	Work:
Name:	Cell:
Address:	Text <input type="radio"/> Yes <input type="radio"/> No
Email:	Home:
	Work:

Custody: Mother Father Both Other (specify): _____

Most recent child care program attended:

(Name) Contact Person (Phone)

Approximate days and times child care will be needed:

MONDAY from _____ to _____
TUESDAY from _____ to _____
WEDNESDAY from _____ to _____
THURSDAY from _____ to _____
FRIDAY from _____ to _____

By signing this application, I/We hereby agree to:

Enroll this child at Linda’s Family Child Care, beginning on _____ (Date).

- Upon acceptance, complete, sign and return all required forms before the first day of care.
- Upon acceptance, pay the following fee/s which are non-refundable if the child is not brought for care:
 - An Annual Enrollment/Supply Fee of \$25.00 (to be submitted with the Intent to Enroll)
 - A Deposit of \$ _____ (one week’s tuition to be submitted with the Intent to Enroll) held for the last week of care.
 - Tuition payment of \$ _____ for the first week of care. (Due the first day of care)

If Applicable:

- A Holding Fee of \$ _____/week to reserve the opening. Payment begins the Monday after the child’s enrollment was accepted, and is due by 5:00 pm Friday each week that the opening is to be held. (Applies only if the space will not be occupied for over 1 month)

Part time care policy is as follows:

Part-time care requires specific days that are paid regardless of attendance. Providers PAID days-off accumulate at half the yearly rate for part-time children.

Medical Information:

I hereby give permission to Linda’s Family Child Care to contact the following medical personnel to obtain emergency medical care if warranted.

(Doctor)	(Address)	(Phone)
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(Hospital Preference)

Please list allergies, special medical or dietary needs, or other areas of concern:

(Parent/Guardian signature)

(Parent/Guardian signature)