



**NEW ENROLLMENT FORM**

Circle Program/s: **Before School** **Afterschool** **Toddler** **Preschool** **Half Day Preschool** **Summer**

Date \_\_\_\_\_

**Child's Name** \_\_\_\_\_ **Birthdate** \_\_\_\_\_ **Age** \_\_\_\_\_ **Sex** \_\_\_\_\_

Home Address \_\_\_\_\_

School \_\_\_\_\_ **Grade as of Sept. 20** \_\_\_\_\_

**Parent/Legal Guardian #1** (if under 18)

Name \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

Home Address \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

City \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

Parent Email: \_\_\_\_\_

Employer's Name \_\_\_\_\_ **Employer Phone:** \_\_\_\_\_

Employer's Address \_\_\_\_\_

City \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Parent/Legal Guardian #2** (if under 18)

Name \_\_\_\_\_

Home Address \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

City \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

Employer's Name \_\_\_\_\_

Business Address \_\_\_\_\_ **Employer Phone:** \_\_\_\_\_

City \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Persons to Whom Child May Be Released/Emergency Contacts:**

Name \_\_\_\_\_ **Relationship** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

Address \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

Name \_\_\_\_\_ **Relationship** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

Address \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

Phone: 717-233-6541

Fax: 717-233-6554

Website: [www.neighborhoodcenterumc.org](http://www.neighborhoodcenterumc.org)

1801 N. 3<sup>rd</sup> Street Harrisburg, PA 17102

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Medical Information:**

Name of Child's Physician or Health Care Provider \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Health Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_

**Medical or Dietary Needs (include allergies, medications, disabilities, and special conditions-  
medications must be in original containers with doctor's directions & parent must sign the medication  
log daily if given in care).**

**By signing my name, I state that the information I have provided is truthful and accurate and I also  
agree to abide by the Center's policies as stated in the Parent Handbook and to update any of the  
above information when required or when changes to the information occur.**

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Person Responsible for payments (please print) \_\_\_\_\_

Signature of Person Responsible for payments \_\_\_\_\_

**Do not write below this line – For administrative purposes only.**

Staff completing this form \_\_\_\_\_

Program \_\_\_\_\_

Date Enrollment Form Received \_\_\_\_\_

Circle Payment Type: Private Pay      CCN      DPW      Scholarship      Other      Rate \_\_\_\_\_

Date Child Scheduled to start \_\_\_\_\_ Withdrawal Date \_\_\_\_\_

**NON-DISCRIMINATION AND AFFIRMATIVE ACTION POLICY**

**It is the policy of Neighborhood Center of the United Methodist Church that there will be no discrimination  
in employment or enrollment with regard to race, color, religious creed, family status, ancestry, national origin,  
age, sex, or disability. Reasonable accommodations shall be made to meet the physical or mental limitations of  
qualified applicants or employees.**

**Our goal is to create a workplace free from discrimination with a staff that is representative of our  
community – men and women of varied religious, racial, cultural and economic backgrounds.**