



GREATER LOVE PRIMARY LEARNING CENTER  
 18200 N.W. 22nd Avenue Miami Gardens, Florida 33056  
 (305) 621-1355 | (305) 621-1352 (fax)  
[greaterloveplc@gmail.com](mailto:greaterloveplc@gmail.com)

**2023-2024**

**Date of Enrollment:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**CHILDCARE APPLICATION FOR ENROLLMENT**

**Student Information:**

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sex: \_\_\_\_\_

Full Name: \_\_\_\_\_

Enrollment Type: \_\_\_\_\_  
 First \_\_\_\_\_ Last \_\_\_\_\_ Middle Initial \_\_\_\_\_ Nickname \_\_\_\_\_  
 Infant \_\_\_\_\_ Ones \_\_\_\_\_ Twos \_\_\_\_\_ Threes \_\_\_\_\_  
 VPK \_\_\_\_\_ Beforecare \_\_\_\_\_ Aftercare \_\_\_\_\_

Name of School Currently attending (other than GLPLC): \_\_\_\_\_

Primary Hours of Care: From: \_\_\_\_\_ To: \_\_\_\_\_

Days of the Week in Care: M T W TH F \_\_\_\_\_

**Family Information:**

Child Lives With: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell: \_\_\_\_\_ Cell: \_\_\_\_\_

Custody: Mother \_\_\_\_\_ Father's \_\_\_\_\_ Both \_\_\_\_\_ Other \_\_\_\_\_

**Medical Information:**

I do grant permission for the staff of this facility to contact the following medical personnel to obtain Emergency Medical Care if warranted.

Doctor: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Doctor: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

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

**Emergency Care Plan Instructions(If applicable):** \_\_\_\_\_

**Emergency Contacts:** Child will be released only to the custodial parent or legal guardian and the persons listed below. The following people will also be contacted and are authorized to remove the child from the facility in case of illness, accident or emergency. If for some reason, the custodial parent or legal guardian cannot be reached:

Name	Work#	Home#	Cell#
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**FOR OFFICE USE ONLY:**

**Date:** \_\_\_\_\_ **Registration Fee Paid:** \_\_\_\_\_ **SR** \_\_\_\_\_ **Private Pay** \_\_\_\_\_  
**Immunization received:** \_\_\_\_\_ **exp date:** \_\_\_\_\_ **Physical received:** \_\_\_\_\_ **Sibling Name:** \_\_\_\_\_