



LAC EARLY CHILDHOOD CENTER

2 Fifth Avenue, New York, NY 10011 (212) 828-3975

APPLICATION FORM

DATE: _____

CHILD INFORMATION

Child Full Name: _____

Child Preferred Name: _____

Gender: Male Female

Date of Birth (MM-DD-YYYY): _____

With Whom Does the Child Live: _____

Intended Start Date: _____

Schedule: 8:00am – 6:00pm 8:30am – 5:30pm 9:00am – 3:30pm

Days / Week: Monday Tuesday Wednesday Thursday Friday

HOME ADDRESS

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone 1: _____ Cell Phone 2: _____

PARENT / GUARDIAN INFORMATION

Parent/Guardian 1 Title: _____

Parent/Guardian 1 Full Name: _____

Parent/Guardian 1 Relation to Child: _____

Parent/Guardian 1 Place of Employment: _____

Business Address: _____

Work Phone: _____

Email 1: _____

Parent/Guardian 2 Title: _____

Parent/Guardian 2 Full Name: _____

Parent/Guardian 2 Relation to Child: _____

Parent/Guardian 2 Place of Employment: _____

Business Address: _____

Work Phone: _____

Email 2: _____

MEDICAL INFORMATION

Does your child have any allergies? Yes No

If yes, explain: _____

Outside services (speech, O.T., P.T.) or medical needs: _____
