



Future Einsteins
42 Severance Green
Colchester, VT 05446
Phone: (802)288-9035

Camp Program at Future Einsteins

Parent/Guardian Information

Parent or Guardian Name _____

_____ Completed Enrollment Forms

_____ Deposit

_____ Subsidy Certificate (if qualified)

_____ Up to date Immunization Record

_____ To Bring Daily: Snack/Juice

Future Einsteins Center Staff Information

Completed by _____

**After School
Enrollment Form**

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Child Information Form

Child's Name _____

Child's Nickname _____

Known Allergies: _____

Does Your Child require an Epi Pen? Yes____ **No**____
(If yes, please provide MD order and Medication)

How should we manage the allergen at school? _____

Prior Childcare Experience _____

**Anything else you would
like us to know about your
child?** _____

Parent or Legal Guardian's Signature: _____

Date: _____

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Enrollment Form

Child's Information

Child's Name: _____

Child's Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Parent or Guardian Information

Parent/Guardian Name _____

Home Address: _____

City: _____ State: _____ Zip: _____

Place of Employment: _____ Work # _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Parent or Guardian Information

Parent/Guardian Name _____

Home Address: _____

City: _____ State: _____ Zip: _____

Place of Employment: _____ Work # _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

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Emergency Release Form

Emergency Information

Child's Name: _____

Child's Doctor _____ Phone _____

Child's Dentist _____ Phone _____

Child's Insurance Information

Health Insurance Company: _____ Policy # _____

Dental Insurance Company: _____ Policy # _____

Parent or Guardian Information

Parent/Guardian Name _____

Work/Cell Phone _____ Home Phone _____

Parent/Guardian Name _____

Work/Cell Phone _____ Home Phone _____

Authorization

I _____ and/or _____ understand the above and hereby authorize any member of the staff at Future Einsteins to give permission for any medical, hospital, or dental treatment for child _____ in the event of injury or illness, while the child is in the care of the above named provider or center. I understand and agree that I would be financially responsible for any medical, hospital, or dental treatments unless my child's injury is due to improper supervision or faulty equipment. I have full understanding that every attempt will be made to contact the parent/guardian in the event medical, hospital, or dental treatment is necessary. I understand that certain medical emergencies may not allow much time for contact of a parent/guardian and that if a life threatening situation arises, immediate medical attention will be sought by the provider/center.

Parent or Legal Guardian's Signature: _____ Date: _____



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Emergency Contact Information

If one of the above parents or guardians cannot be reached in an emergency or illness, please contact one of the following individuals. **The State of Vermont requires that we have on file, the current names and daytime phone numbers of at least two individuals that can pick up your child if we cannot reach you.**

The following people have permission to pick up my/our child without written notification.

Emergency Contact Person

Emergency Contact's Name _____

Home Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____ Cell Phone: _____

Emergency Contact Person

Emergency Contact's Name _____

Home Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____ Cell Phone: _____

Authorization

Parent or Legal Guardian's Signature: _____

Date: _____

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Photo Release Form

Child's Information

Child's Name: _____

Photo Release

Please check the appropriate box

I give permission to Future Einsteins to take or have photos take of my child. I understand that these photos will not be sold or distributed without my knowledge or permission.

I do not give permission to Future Einsteins to take photos of my child.

Please check the appropriate box

I give permission to Future Einsteins to videotape or have videotapes taken of my child. I understand that these videotapes will not be sold or distributed without my knowledge or permission.

I do not give permission to Future Einsteins to videotape or have videotapes taken of my child.

Please check the appropriate box

I give permission to Future Einsteins to include photographs of my children on marketing materials and/or on the www.futureeinsteinsvt.weebly.com web site. I understand that my child's name will not be used on the web site or on the marketing materials.

I do not give permission to Future Einsteins to include photographs of my children on marketing materials and/or on the www.futureeinsteinsvt.weebly.com web site.

Authorization

By signing this document, I am confirming my choice to either grant or deny the photographing or videotaping of my children while they are enrolled and attending Future Einsteins

Parent or Legal Guardian's Signature: _____ **Date:** _____

Future Einsteins Authorized Signature: _____ **Date:** _____



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To be filled out by health care provider

CHILD CARE GENERAL HEALTH EXAMINATION FORM

Child's Name: _____

Date of Birth: _____ Date of Last Exam: _____

_____ This child has no health conditions or medications that impact enrollment in child care.

_____ This child has a condition or medication that should be known by the child care provider.

Health Care Provider Name: _____

Phone Number: _____

Health Care Provider Signature: _____

Date: _____