



Little Lambs Learning Center

424 Forest Ave.
Glen Ellyn, IL 60137
pdo@geumc.org
630-664-5451

Little Lambs Learning Center Registration Form

Child's Name: _____
Date of Birth: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Address: _____
Home Phone: _____ Child lives with: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both <input type="checkbox"/> Other: _____

Please provide information below for all those who have legal or financial responsibility for this child.

Mother/Guardian: _____ Marital Status: _____
Address (if different): _____
Phone: _____ <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work
Phone: _____ <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work
Email: _____
Occupation: _____ Employer: _____
Work Address: _____ Work Hours: _____
Preferred method of contact: <input type="checkbox"/> phone <input type="checkbox"/> email <input type="checkbox"/> text

Father/Guardian: _____ Marital Status: _____
Address (if different): _____
Phone: _____ <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work
Phone: _____ <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work
Email: _____
Occupation: _____ Employer: _____
Work Address: _____ Work Hours: _____
Preferred method of contact: <input type="checkbox"/> phone <input type="checkbox"/> email <input type="checkbox"/> text

Child's Physician: _____ Phone: _____
Office Address: _____
Allergies/ Special Requirements: _____



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Please provide the names of those authorized to pick up this child - **other than parents/guardians.**

Name _____	Phone: _____
Address: _____	Relationship: _____

Name _____	Phone: _____
Address: _____	Relationship: _____

Name _____	Phone: _____
Address: _____	Relationship: _____

Emergency Contacts: Please rank according to whom we should contact first and how to best reach them.

1. Name: _____	Relationship to child: _____
Phone: _____	Phone: _____
2. Name: _____	Relationship to child: _____
Phone: _____	Phone: _____
3. Name: _____	Relationship to child: _____
Phone: _____	Phone: _____
4. Name: _____	Relationship to child: _____
Phone: _____	Phone: _____

Preferred Schedule: <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F	Preferred Start Date: _____
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How did you hear about Little Lambs? _____
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I affirm that the information provided in this application is true and complete to the best of my knowledge.	
Parent/Guardian Signature: _____	Date: _____
Parent/Guardian Signature: _____	Date: _____



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Please share a little information about your child:

Medical problems: _____

Physical limitations: _____

Restrictions for play: _____

Food likes: _____

Food dislikes: _____

Fears: _____

Is your child toilet trained? _____

Does your child have special names for objects? (potty, cookies, drinks, etc.) _____

Other information that will help in caring for your child: _____

ALL INFORMATION SHALL BE REGARDED AND HANDLED CONFIDENTIALLY