APPLICATION FOR ENROLLMENT
Beacon Center for Children

Name of Child_____Date of Birth_____
Address_____
City State Zip
Previous nursery/child care experience:_____

Mother's Name_____Father's Name_____
(or legal guardian) (or legal guardian)
Home Address_____Home Address_____
_____ _____
City State Zip City State Zip
Email_____ Email_____
Home Phone_____ Home Phone_____
Work Phone_____ Work Phone_____
Cell Phone_____ Cell Phone_____

Special Disability, if any_____
Special medical/dietary information necessary for management in emergency situation; allergies, medications, special conditions_____
_____

I wish my child to be enrolled in:

____Full-time Program ____Part-time program:____Mon.____Tues.
(5) days 8:00 - 6:00 p.m. ____Wed. ____Thurs. ____Fri.

____School Age After- ____8:00-12:30 p.m. ____8:00-1:00 p.m.
School Program ____8:00-3:00 p.m. ____8:00-6:00 p.m.
____Mon. ____Tues. ____1:00-5:00
____Wed. ____Thurs. ____Fri.

Desired Date of Enrollment:_____Signature of Parent_____
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Please return application along with application fee of $50.00 (non-refundable). Make check payable to Beacon Center for Children.

Linda M. Burns, Director
Beacon Center for Children
2125 Chestnut Street
Philadelphia, PA 19103
(215) 963-0748

Thank you.

For Official Use Only

Date of Receipt of Application_____ Start Date_____