

# Enrollment Form I

Bright Eyes Kindergarten, Inc.

## STUDENT INFORMATION

Expected Enrollment Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Sex: M F DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ Name  
Name Child Goes By: \_\_\_\_\_ Lives with: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Mother/Guardian: \_\_\_\_\_ Employer: \_\_\_\_\_  
Home: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
Mother/Guardian Email: \_\_\_\_\_

Father/Guardian: \_\_\_\_\_ Employer: \_\_\_\_\_  
Home: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
Father/Guardian Email: \_\_\_\_\_

Other Siblings Enrolled/Age: \_\_\_\_\_  
\_\_\_\_\_

## EMERGENCY CONTACTS & PICKUP INFORMATION

Name: \_\_\_\_\_  Grandparent  Friend/Neighbor  Relative  
Home: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Name: \_\_\_\_\_  Grandparent  Friend/Neighbor  Relative  
Home: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Name: \_\_\_\_\_  Grandparent  Friend/Neighbor  Relative  
Home: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Name: \_\_\_\_\_  Grandparent  Friend/Neighbor  Relative  
Home: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_-\_\_\_\_

List ALL persons NOT AUTHORIZED to pick up:

1. \_\_\_\_\_

2. \_\_\_\_\_

Bright Eyes Kindergarten, Inc.

2036 Roper Mountain Road • Greenville, SC 29615 • (864) 297-7882

[www.brighteyeskindergarten.com](http://www.brighteyeskindergarten.com)

# Enrollment Form II

Bright Eyes Kindergarten, Inc.

## MEDICAL INFORMATION

Child's Physician : \_\_\_\_\_ Name of Facility: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_


My Child does not have insurance

Insurance Provider: \_\_\_\_\_ Policy/Group ID#: \_\_\_\_\_  
Name of Insured/Policy Holder: \_\_\_\_\_ Employer: \_\_\_\_\_  
Hospital of Choice:  GHS  Hillcrest  St. Francis Women's  St. Francis Downtown

It is now required that we also have a photo copy of the applicable insurance card.

Immunizations:  Current  Date of next scheduled immunization: \_\_\_\_\_

Current Medications & Frequency: \_\_\_\_\_

 Allergies (List ALL known allergies): \_\_\_\_\_

Has your child ever experienced an allergic reaction? If so, how was it treated and how will you expect Bright Eyes to respond? \_\_\_\_\_

Medical History:  Recent Surgery/Serious Injury  Chronic/Recurring Illness  
 Physical/Mental Condition  Other

Please tell us about any medical issues/conditions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I acknowledge that the information I have provided on Enrollment Forms I & II are accurate and complete. I will notify Bright Eyes Kindergarten, Inc. as changes occur.

\_\_\_\_\_  
Signature of Parent/Guardian

## MEDIA CONSENT

Bright Eyes Kindergarten, Inc. request permission to photograph your child, record your child on video tape/audiovisual equipment while participating in our program for the following purposes: bulletin boards, newspapers, brochures/school literature, website, participation in special events, etc.

*I grant permission to Bright Eyes Kindergarten, Inc. to photograph my child(ren) according to the media consent outlined in this enrollment form.*

Provide an 8-digit password for web access: \_\_\_\_\_  
(\$50 processing fee each time password is reset)

\_\_\_\_\_  
Signature of Parent/Guardian