



**Paramount Child Development Center Prep School**  
**3924 4<sup>th</sup> Street, Southeast**  
**Washington, DC 20032**  
**(202)562-3404**  
**(202)563-3653 Fax**

**Email: [Paramountchilddevelopmentcenter@outlook.com](mailto:Paramountchilddevelopmentcenter@outlook.com)**

**ENROLLMENT FORM**

**Family Information**

<p>1. Parent: <input type="checkbox"/> Custodial <input type="checkbox"/> Guardian: <input type="checkbox"/> Grandparent: <input type="checkbox"/> Foster: <input type="checkbox"/>  Relationship to Child: _____ Social Security No. _____  Last Name: _____ First Name: _____ M.I. _____  Street Address: _____ Apt. No. _____ Ward _____  City: _____ State: _____ Zip Code: _____  Home Phone: ( ) _____ Work: ( ) _____ Cell ( ) _____  Email: _____</p>
<p>2. Parent: <input type="checkbox"/> Custodial <input type="checkbox"/> Guardian: <input type="checkbox"/> Grandparent: <input type="checkbox"/> Foster: <input type="checkbox"/>  Relationship to Child: _____ Social Security No. _____  Last Name: _____ First Name: _____ M.I. _____  Street Address: _____ Apt. No. _____ Ward _____  City: _____ State: _____ Zip Code: _____  Home Phone: ( ) _____ Work: ( ) _____ Cell ( ) _____  Email: _____</p>

**Child Information**

<p>1. Last Name: _____ First Name: _____ M.I. _____  Sex: M <input type="checkbox"/> F <input type="checkbox"/> O <input type="checkbox"/> DOB: __/__/__ Social Security No. _____  Emergency Contact: _____ Relationship/Phone No: _____  PCP(Doctor): _____ Phone No. _____  PCP (Dentist): _____ Phone No. _____  Insurance Provider: _____ Policy No. _____  Last Physical/Date: _____ Known Allergies: _____</p>
<p>2. Last Name: _____ First Name: _____ M.I. _____  Sex: M <input type="checkbox"/> F <input type="checkbox"/> O <input type="checkbox"/> DOB: __/__/__ Social Security No. _____  Emergency Contact: _____ Relationship/Phone No: _____  PCP(Doctor): _____ Phone No. _____  PCP (Dentist): _____ Phone No. _____  Insurance Provider: _____ Policy No. _____  Last Physical/Date: _____ Known Allergies: _____</p>



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**EMERGENCY CARE AUTHROIZATION**

I certify that I am a parent or legal guardian of the child or children named above and give consent for emergency medical and/or surgical treatment, and/or transportation to a care facility should my child's condition require it in my absence. I understand that, time and conditions permitting, reasonable attempts will first be made to contact me and any designated representatives in such a case. I hereby assume all financial responsibility for such actions taken on behalf of my child.

\_\_\_\_\_  
Parent/Legal Guardian's Signature

\_\_\_\_\_  
Date

**FOR OFFICIAL USE ONLY**

TUTION \$ \_\_\_\_\_ CLASSROOM: \_\_\_\_\_ ENROLLED: \_\_\_\_\_