

EARLY EDUCATION CENTER
GROVE CITY COLLEGE
100 CAMPUS DRIVE
GROVE CITY, PA 16127

APPLICATION FORM

----- TUES/THURS ----- AM ----- PM (preference)
----- MON/WED/FRI ----- AM ----- PM (preference)

CHILD'S NAME -----
(Last) (First) (Middle)

Nick Name (If preferred for classroom) -----

Date of Birth -----

Address -----

E mail address(es) -----

Mother (or legal guardian)

Father (or legal guardian)

Name -----

Name -----

Address -----

Address -----

Phone # (home) -----

Phone # (home) -----

(cell) -----

(cell) -----

(work) -----

(work) -----

Occupation -----

Occupation -----

Business Name -----

Business Name -----

PERSONS OTHER THAN PARENTS TO CONTACT IN CASE OF EMERGENCY

*Please list persons who could come to classroom quickly if needed

Name -----

Name -----

Address -----

Address -----

Contact Phone # -----

Contact Phone # -----

(during class time)

(during class time)

Relationship to Child -----

Relationship to Child -----

**NOTE: THE APPLICATION IS NOT CONSIDERED COMPLETE WITHOUT THE
\$35.00 NON-REFUNDABLE REGISTRATION FEE.**

MEDICAL INFORMATION

1. List medical/hospital insurance carrier _____

2. Name of your child's physician _____

Address _____

Phone _____

Do you want your doctor called in case of an emergency if you are unable to be reached?

Yes _____ No _____

3. List any allergies your child may have:

4. List any known problems your child has:

5. List any medications given on a regular basis:

6. Immunization Data: (List Month/Year) - (PLEASE Follow the Required Immunization schedule of your child's pediatrician)

Hep B	1st _____	2nd _____	3rd _____		
DTaP	1st _____	2nd _____	3rd _____	4th _____	5th _____
OPV/IPV	1st _____	2nd _____	3rd _____	4th _____	
HIB	1st _____	2nd _____	3rd _____	4th _____	
MMR	1st _____	2nd _____			
Chicken Pox	1st _____				

I hereby give consent for emergency treatment and hospitalization for the child below if I am not available to give consent at the time of need. In my absence the Grove City United Community Hospital or other appropriate hospital is authorized to perform and arrange for any necessary treatment and hospitalization that is required including the obtaining of physician specialist, in the absence of the physician listed above, that may be necessary for treatment.

NOTE: Every effort will be made to contact the parents or other persons indicated on page 1.

I hereby acknowledge that the registration fee is non-refundable.

I hereby give permission for EEC personnel to include all contact information (except for emergency information) on separate class session contact sheets and email distribution lists. EEC personnel and families ONLY will use these lists to share IMPORTANT EEC information.

Signature of Parent _____ Date _____

Child's Name _____

Please mail completed application and registration fee to:
Grove City College Early Education Center
C/O Carolyn Patterson
100 Campus Drive , GCC # 3031
Grove City, PA 16127