

**ENROLLMENT WORKSHEET**

**BJ Jordan Child Care Programs**

**3325 Myrtle Ave**

**North Highlands**

**CA 95660**

**CHILD INFO:**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Enrollment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_ Male \_\_\_\_ Female

**PARENT INFO:**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Sex: \_\_\_\_ Male \_\_\_\_ Female Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Email: \_\_\_\_\_

**FORMULA OPTION:**

**FOOD OPTION:**

\_\_\_\_ Parent Supplies Breast Milk or Formula  
\_\_\_\_ Parent Accepts Provider-Supplied Formula  
Name of Parent Formula: \_\_\_\_\_

\_\_\_\_ Parent Supplies Additional Food and Refuses Provider's Foods  
\_\_\_\_ Provider Supplies Additional Foods When Developmentally Appropriate

**SCHOOL INFO:**

**CHILD'S RACE:**

\_\_\_\_ School Age      \_\_\_\_ AM Kindergarten      \_\_\_\_ AM Headstart      \_\_\_\_ Hispanic/Latino      \_\_\_\_ Black or African American  
\_\_\_\_ Home School      \_\_\_\_ PM Kindergarten      \_\_\_\_ PM Headstart      \_\_\_\_ White (Not Hispanic)      \_\_\_\_ American Indian /  
\_\_\_\_ All Year School      \_\_\_\_ All Day Kindergarten      \_\_\_\_ All Day Headstart      \_\_\_\_ Asian      \_\_\_\_ Alaska Native  
\_\_\_\_ Native Hawaiian /  
\_\_\_\_ Pacific Islander

School Name: \_\_\_\_\_

School Number: \_\_\_\_\_ School District: \_\_\_\_\_

School Depart Time: \_\_\_\_\_ : \_\_\_\_\_ AM / PM      Return Time: \_\_\_\_\_ : \_\_\_\_\_ AM / PM

Days Attending School: \_\_\_\_ MON \_\_\_\_ TUE \_\_\_\_ WED \_\_\_\_ THU \_\_\_\_ FRI

**CHILD ATTENDANCE:**

I anticipate the Days my child will participate will be: \_\_\_\_ MON \_\_\_\_ TUE \_\_\_\_ WED \_\_\_\_ THU \_\_\_\_ FRI \_\_\_\_ SAT \_\_\_\_ SUN \_\_\_\_ Days will vary

Drop Off Time \_\_\_\_\_ : \_\_\_\_\_ AM / PM      Pick Up Time \_\_\_\_\_ : \_\_\_\_\_ AM / PM      \_\_\_\_ Times will vary

I anticipate the Meals my child will participate will be: \_\_\_\_ Breakfast \_\_\_\_ AM Snack \_\_\_\_ Lunch \_\_\_\_ PM Snack \_\_\_\_ Dinner \_\_\_\_ Evening Snack

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**- FOR PROVIDER USE -**

**RELATIONSHIP TO PROVIDER**

<input type="checkbox"/> Not related	Special needs Child	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Child will participate in CACFP	<input type="checkbox"/> Yes
<input type="checkbox"/> Related, non-resident	Special diet	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Child Number: _____	
<input type="checkbox"/> Own Child	If special diet, explain			Child Group: _____	
<input type="checkbox"/> Helper's Child	_____				
<input type="checkbox"/> Foster Child	_____				