



475 GRAND CONCOURSE, RM 109A, BRONX, N.Y. 10451
 TEL NO.: (718) 518-4176

ENROLLMENT FORM

PARENT/GUARDIAN INFORMATION

DATE: _____ SEMESTER FOR CHILD CARE _____

PARENT/GUARDIAN FIRST NAME: _____ LAST NAME: _____

HOSTOS COMMUNITY COLLEGE EMPLID: _____

ADDRESS: _____ APT: _____

CITY/STATE/ZIPCODE: _____

CELL PHONE: (____) _____ - _____ HOME PHONE (____) _____ - _____

PERSONAL EMAIL ADDRESS: _____ HOSTOS EMAIL ADDRESS: _____

RELATIONSHIP TO CHILD: MOTHER: ___ FATHER: ___ OTHER: _____

FAMILY COMPOSITION: SINGLE _____ MARRIED _____ OTHER _____

HOSTOS COMMUNITY COLLEGE MAJOR OF STUDY _____

EXPECTED GRADUATION DATE: _____

CHILD INFORMATION

CHILD'S FIRST NAME: _____ CHILD'S LAST NAME: _____

CHILD'S DOB: _____ SEX: Male Female X

Below select the ethnicity and racial category for your child

Section I. Ethnic Category

	Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American; or other Spanish culture or origin, regardless of race.
	Not Hispanic or Latino

Section II. Racial Category

	American Indian or Alaskan Native —A person having origins in any of the original People of North or South America, who maintains tribal affiliations or community attachment (includes Aleuts and Eskimos)
	Asian —A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent. This China, Japan, Korea, India, and the Philippine Islands.
	Black of African American – A person having origins in any of the black racial groups of Africa
	Native Hawaiian or other Pacific Islander —A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.
	White —A person having origins in any of the original peoples of Europe, North Africa or the Middle East
	Two or more races —two or more of the above racial groups peoples

Primary Language Spoken at Home: _____

SCHEDULE

Use the table below to indicate the days and time you will need child care. The time in the chart will reflect the time your child will be dropped off and picked up. Please note the center is open from 7:45 a.m. to 5 p.m.

Monday	Tuesday	Wednesday	Thursday	Friday	Weekly Total
From: _____	From: _____	From: _____	From: _____	From: _____	
To: _____	To: _____	To: _____	To: _____	To: _____	_____

Parent's/Guardian's Signature: _____ Date: _____

HEALTH, DIETARY, and SPECIAL NEEDS SECTION

PARENT/GUARDIAN INFORMATION

Date: _____

PARENT/GUARDIAN FIRST NAME: _____ LAST NAME: _____

HOSTOS COMMUNITY COLLEGE EMPLID: _____ LAST FOUR OF SSN: _____

CHILD INFORMATION

CHILD'S FIRST NAME: _____ CHILD'S LAST NAME: _____

CHILD'S DATE OF BIRTH: _____ SEX: Male Female X

CHILD'S HEALTH, DIETARY, and SPECIAL NEEDS:

• Has a **MEDICAL CONDITION** (such as Asthma, Respiratory issues, Seizures, Diabetes, Hearing, etc.)

No Yes—please explain _____

• Has **MEDICATION PRESCRIBED BY A DOCTOR** (he/she will need to take during school hours)

No Yes—please explain _____

• Has allergic reactions insect bites?

No Yes—please explain _____

• Has allergic reactions to materials/fabrics like metal, pollen, latex, dust, etc.?

No Yes—please explain _____

• Has other allergic reactions (Soaps, Creams, lotions, etc.)?

No Yes—please explain _____



Food Allergies and Preferences:

- Has **FOOD ALLERGIES**

No Yes—please explain _____

Requires **SPECIAL DIET** due to medical or allergy condition OR personal preference (such as dairy-free, no pork, etc.)

SPECIAL NEEDS—MY CHILD: If you answer yes to any of the questions below, you must provide a copy of all supporting documents.

- Receives or did receive **SERVICES FOR SPECIAL NEEDS** from school district OR other agencies:

No Yes—please explain _____

- Has an **INDIVIDUAL EDUCATION PLAN (IEP) OR INDIVIDUAL FAMILY SERVICE PLAN (IFSP)**

No Yes—please explain _____

- Has been **IDENTIFIED/ASSESSED FOR SPECIAL NEEDS** (ADHD, Speech Therapy, Autism Spectrum Disorder, etc.):

No Yes—please explain _____

By signing below I attest I have answered all questions truthfully. I understand my responsibility to immediately inform the Hostos Community College Children’s Center, Inc. of any changes in my child’s health, dietary, and/or special needs.

Print Name

Date

Signature