



BILINGUAL • DAYCARE • PRE-SCHOOL

Petits Poussins Too 2235 Frederick Douglass Blvd. New York, NY 10027

APPLICATION: ONE-TIME FAMILY FEE: \$ 200.00

Academic year: ____ / ____ **What would be your ideal start date?** _____

Program: Infant Toddler Preschool

Child's name: First _____ (Middle) _____ Last _____

Date of Birth: _____ Place of Birth: _____ Sex: ____ Age on Sept 1: ____ yr ____ months

Street Address: _____ City: _____ Zip Code: _____

Guardian 1: **Mother** **Father**

Guardian 2 : **Mother** **Father**

First & Last name: _____
Cell number: (____) _____
Email: _____
Employer: _____
Business: (____) _____
Home phone#: (____) _____

First & Last name: _____
Cell number:(____) _____
Email: _____
Employer: _____
Business: (____) _____

Does your child speak French? (Y) (N) Do parents speak French? (Y) (N)

If parents are not at same address, who should we address correspondence to?

→ **In case of Emergency name of relative or friend who can be called if we are unable to reach you:**

Name: _____ Telephone: (____) _____

Street Address: _____ City: _____ Zip Code: _____

Name of Doctor to be called in case of Emergency: _____

Telephone of Doctor: (____) _____



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SEPTEMBER- JUNE

- Full Day (Monday through Friday):** 8:00 am - 3:00 pm
- Three Days (Monday, Wednesday & Friday):** 8:00 am - 3:00 pm
- Two Days (Tuesday & Thursday):** 8:00 am - 3:00 pm
- Enrichment** 3:00 pm-6:00pm: Monday through Friday

Please mail your application to:

**Petits Poussins Too
 (C/O Vanessa Handal-Ghenania)
 2235 Frederick Douglass Blvd,
 Store Front
 New York, NY 10027**

Medical Statements and Consent:

Petits Poussins Too is not permitted to administer any medication, if needed, please do so at home or after school.

I (we) authorize staff and Director of Petits Poussins Too to **obtain** all necessary Emergency Medical treatment, in case of an emergency? _____(Parent Initial)

Do you authorize staff and Director of Petits Poussins Too to administer all necessary First Aid care for your child, if necessary? (Y) (N) _____(Parent Initial)

*List any allergies your child has, or medical conditions, seizures, Asthma, handicap, he/she has:

 *Note: All allergies/medical conditions must be stated on the child’s medical form. Additionally, a “Standing order” from the Pediatrician will be required in order to administer an Epi-Pen, Benadryl, or any Asthma medication. Your child will not be admitted without it.

Does your child have any disability? (Y) (N) If yes, please specify _____

Any speech delays? (Y) (N) If yes, please specify _____

New York Department of Health requires that all children are vaccinated for school entrance.

Do you vaccinate your child? (Y) (N)

I, hereby, authorize Petits Poussins Too to provide care for my child.

I declare to the best of my knowledge that all the statements made in this application are true.

First & Last name (Guardian 1):_____ First & Last name (Guardian 2):_____

Signature:_____ Signature:_____

Date:_____ Date:_____