

OFFICE USE ONLY:

DATE RECEIVED ___/___/___

RECEIVED BY _____

**CLEMSON UNITED METHODIST
CHILD CARE CENTER
APPLICATION FOR INFANT CARE**

CHILD'S FULL NAME: _____

NAME CHILD GOES BY: _____

CHILD'S BIRTHDATE: ___/___/___

CHILD LIVES WITH: MOTHER () FATHER ()

MOTHER'S NAME: _____

MOTHER'S ADDRESS: _____

MOTHER'S CONTACT INFO: (HOME) ___-___-_____

(WORK) ___-___-_____

(CELL) ___-___-_____

MOTHER'S PLACE OF EMPLOYMENT: _____

FATHER'S NAME: _____

FATHER'S ADDRESS: _____

(IF DIFFERENT)

FATHER'S CONTACT INFO: (HOME) ___-___-_____

(WORK) ___-___-_____

(CELL) ___-___-_____

FATHER'S PLACE OF EMPLOYMENT: _____

HOURS NEEDED FOR CARE? _____