**Child Information** Today’s Date:

**List Group you’d like your child to be enrolled in:**

First Name: M.I. Last Name:

Name child prefers to be called: Grade/Class:

Child’s Address: \_

Gender: [ ] Male [ ] Female Date of Birth: Child’s S.S. #:

List any existing medical conditions, medication and/or special attention your child may require?

Allergies:

Pediatrician’s Name: \_ Phone:

Address:

Photographs: May we take and maintain a photo of your child for security purposes? [ ] Yes [ ] No

**Parent/Guardian Information**

**Mother/Guardian**  First Name: M.I. Last Name:

Address:

Occupation: Home Phone:

Employed By: Office Phone: ( )

Work Address: Cell Phone: ( )

[X] Custodial Parent (If married, mark both parents) Email:

Marital Status:[ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Father/Guardian**  First Name: M.I. Last Name:

Address:

Occupation: Home Phone:

Employed By: Office Phone: ( )

Work Address: Cell Phone: ( )

[ X] Custodial Parent (If married, mark both parents) Email:

Marital Status:[ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment Information:**

Current Group Amount: **$**  [ ] Weekly [ ] Bi-Weekly **[X] Monthly** [ ] Other

**Medical insurance will not be billed for payment, but parents can submit our statements to their insurance company for reimbursement.**

Person responsible for bill: Birth date: \_

Address (if different): \_

Occupation: Home Phone: ( )

Employed By: Employer address:

Employer phone no.: ( ) Is this child covered by insurance? [ ] Yes[ ] No

Please indicate primary authorization method [ ] Visa[ ] Check [ ] cash [ ] Other

**Subscriber’s name** First Name: Erin M.I. Last Name: Schorr

Subscriber’s S.S. no. Birth date: \_

Group no.: Policy no.:

Child’s relationship to subscriber: [ ] Self [ ]Spouse [ ] Child [ ] Other

**Name of secondary insurance (if applicable):**

**Subscriber’s name** First Name: M.I. Last Name: Group no.: Policy no.:

Child’s relationship to subscriber: [ ] Self [ ]Spouse [ ] Child [ ] Other

**Emergency Contacts & Authorized Pickup Persons:**

**1st Contact/Pick Up** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:

Relationship to the Child: grandparent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Able to pick up   
[ ] Not able to pick up, use just as an emergency contact

**2nd Contact/Pick Up**  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:

Relationship to the Child: grandparent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Able to pick up   
[ ] Not able to pick up, use just as an emergency contact

**Additional Comments & Information:**

Is there is any other information that that would be helpful to our management and clinical team?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
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The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I also authorize The Barry Group or insurance company to release any information required for reimbursement eligibility.

**Signature:**

Parent’s Signature: Date:

**Thank You!**