

# Tender Years

Learning Center

## 20\_\_ - 20\_\_ Registration Form

507 Walnut Hill Road  
North Yarmouth, ME 04097  
(207) 829-6062

www.tender-years.com

Child's Birth date: \_\_\_\_\_

Child's Last Name: \_\_\_\_\_

Child's First Name: \_\_\_\_\_

Gender: \_\_\_\_\_ (Please circle)  
M F

Street Address

Town

Zip Code

Telephone

3-4 year old Programs (Child must be 3 by October 15 <sup>th</sup> )		
2 AM	Tuesday & Thursday(8:30-11:30)	
2 FULL	Tuesday & Thursday(7:30-5:30)	
AM	Daily Morning Extended Care (7:30 am – 8:30am))	
Other	Alternative Schedule authorized by Karen Bruder _____	

4-5 year old Programs (Child must be 4 by October 15 <sup>th</sup> )		
3 AM	Monday, Wednesday & Friday (8:30-11:30)	
5 AM	Monday through Friday (8:30-11:30)	
3 FULL	Monday, Wednesday & Friday (7:30-5:30)	
5 FULL	Monday through Friday (7:30-5:30)	
AM	Daily Morning Extended Care (7:30 am – 8:30am))	
Other	Alternative Schedule authorized by Karen Bruder _____	

### PARENT 1

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Street Address \_\_\_\_\_ Town \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_

### PARENT 2

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

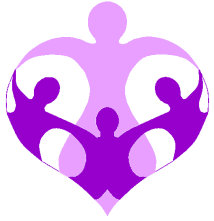
Street Address \_\_\_\_\_ Town \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_



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Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	My child's information may be shared and included in a class directory.
<input type="checkbox"/>	<input type="checkbox"/>	My child is the sibling of a TYLC alumni. List alumna/alumnus name here _____
<input type="checkbox"/>	<input type="checkbox"/>	Does your child have any health problems? If yes, please explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Any known allergies? If yes, please list here: _____
<input type="checkbox"/>	<input type="checkbox"/>	Are there any foods your child cannot eat? If yes, please list here: _____
<input type="checkbox"/>	<input type="checkbox"/>	Any vision, hearing, or speech problems? If yes, please explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Are there any medications given regularly? If yes, please list here: _____

\_\_\_\_\_  
Signature of Parent/Guardian 18 years of age or older:

\_\_\_\_\_  
Date: