CHILD REGISTRATION

Child's Full Name: _____

Address: _____

Gender: Boy_____ Girl _____Birthday: _____ Age: _____

Does your child have allergies? Yes_____ No_____
If yes, what? _____

Does your child have medical conditions? Yes _____No _____
If yes, what? _____

Does your child take any medications? Yes_____ No_____
If yes, please list medication(s): _____
_____

Authorization for Medical Attention:

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician: _____

Address: _____ Phone: _____

Name of the Emergency Care Facility: _____

Address: _____ Phone: _____

I give consent for the facility to secure any and all necessary emergency medical care for my child.

Parent Signature: _____ Date: _____

Please note that you must provide a current copy of your child's Immunization records before they can begin school.

Parent/Guardian Information

Name: _____

Phone: _____Email:_____

Name: _____

Phone:_____ Email:_____

Emergency Contact

Name: _____
Relationship:_____ Phone Number:_____

Name: _____
Relationship:_____ Phone Number:_____

Media Permissions

I give permission for the following (check all that apply; leave blank if you do not give permission)

___ Photos to be taken of my child and posted within facility/program

___ Photos to be taken of my child and on posted online (website, social media, online ads, etc.)

___ Photos to be taken of my child and used for flyers or posters

I certify that all information provided on this form is true and correct to the best of my knowledge.

Parent Signature: _____ Date: _____