

GRACE CHRISTIAN SCHOOL DAY CARE ENROLLMENT FORM

(Please return forms to the Day Care immediately)

CHILD'S NAME: _____ GRADE: _____

ADDRESS: _____ PHONE: _____

WITH WHOM DOES THE CHILD RESIDE? _____

RELATIONSHIP? _____

BIRTHDATE: _____ AGE: _____ MALE: ___ FEMALE: ___
MONTH DAY YEAR

FATHER'S NAME: _____ WORK PHONE: _____

EMPLOYER: _____

MOTHER'S NAME: _____ WORK PHONE: _____

EMPLOYER: _____

NAMES OF ALL PERSONS TO WHOM THE CHILD MAY BE RELEASED:

<u>NAME</u>	<u>ADDRESS</u>	<u>RELATIONSHIP</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

RESPONSIBLE ADULT TO CONTACT IF PARENTS CANNOT BE REACHED:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ HOME PHONE: _____

WORK PHONE: _____

PHYSICIAN'S NAME: _____ PHONE: _____



PLEASE LIST ANY MODIFICATIONS TO YOUR CHILD'S DIET
REQUIRED FOR RELIGIOUS REASONS:

DATE

SIGNATURE OF PARENT/GUARDIAN

PLEASE LIST ANY MODIFICATION TO YOUR CHILD'S DIET REQUIRED
BY PRESCRIPTION FROM A PHYSICIAN OR MEDICAL AUTHORITY:

DATE

SIGNATURE OF PARENT/GUARDIAN

LIST BELOW ANY KNOWN ALLERGIES, PHYSICAL OR MENTAL
PROBLEMS, MENTAL RETARDATION OR DEVELOPMENTAL
DISABILITIES THAT WOULD PREVENT YOUR CHILD FROM
PARTICIPATING IN THE CENTER'S REGULAR PROGRAM AND
ACTIVITIES:

LIST BELOW ANY SPECIAL PROCEDURES TO BE FOLLOWED IN THE
CARE OF YOUR CHILD AND ANY SPECIAL CARE OF YOUR CHILD AND
ANY SPECIAL SERVICES THE CENTER HAS AGREED TO PROVIDE YOUR
CHILD:

DATE

SIGNATURE OF PARENT/GUARDIAN

EMERGENCY MEDICAL AUTHORIZATION

Should _____, _____ suffer an
Child's Name Date of Birth

Injury or illness while in the care of Grace Christian Extended Care and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

I (We) agree to keep the facility informed of changes in telephone numbers, etc. where I (we) can be reached.

The facility agrees to keep me informed of any incidents requiring professional medical attention involving my child.

Child's primary source of health care is:

Physician/Clinic Name Phone Number

Address of Physician/Clinic

Known medical conditions (i.e. diabetic, asthmatic, drug allergies)

Signature of Parent/Guardian

Date

Phone Number