



Registration Form

Enrollment Date _____	Age _____
_____ Traditional	_____ M/W/F _____ T/TR
Reg. Paid _____	Date: _____
<i>Office Use Only</i>	

Child's Name _____ Child's Birth Date _____ Gender _____

Address _____
Street City Zip

Home Phone/Cell Phone Number _____

Father or Guardian's Name _____

Father or Guardian's Employer _____ Work Phone Number _____

E-mail Address _____ Work Schedule _____

Mother or Guardian's Name _____

Mother or Guardian's Employer _____ Work Phone Number _____

E-mail Address _____ Work Schedule _____

Child lives with: (Check one) Both Parents _____ Mother _____ Father _____ Legal Guardian _____

HEALTH CARE NEEDS: For any child with health care needs such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child's parent or health care professional. Is there a medical action plan attached? Yes__ No__

List any allergies and the symptoms and type of response required for allergic reactions. _____

List any health care needs or concerns, symptoms of and type of response for these health care needs or concerns. _____

List any particular fears or unique behavior characteristics the child has _____

List any types of medication taken for health care needs _____

Share any other information that has a direct bearing on assuring safe medical treatment for your child _____

