



## 2019-2020 Registration Form

If your child is under the age of 2 by 9/1/19, you may register for one or two days per week. If your child is 2 years of age or older on 9/1/19, you may only register for two days per week.

Child #1's Name \_\_\_\_\_ Child #1's Birth Date \_\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_

Month Day Year

I am registering for: \_\_\_\_\_ 2 days per week **OR** \_\_\_\_\_ 1 day per week (Circle One): Tuesday Thursday

Child #2's Name \_\_\_\_\_ Child #2's Birth Date \_\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_

Month Day Year

I am registering for: \_\_\_\_\_ 2 days per week **OR** \_\_\_\_\_ 1 day per week (Circle One): Tuesday Thursday

Child #3's Name \_\_\_\_\_ Child #3's Birth Date \_\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_

Month Day Year

I am registering for: \_\_\_\_\_ 2 days per week **OR** \_\_\_\_\_ 1 day per week (Circle One): Tuesday Thursday

Address \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

City

State

Zip Code

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Mother's Cell Phone # \_\_\_\_\_ Father's Cell Phone # \_\_\_\_\_

Mother's Work Number \_\_\_\_\_ Father's Work Number \_\_\_\_\_

Mother's Driver's License # \_\_\_\_\_ Father's Drivers License # \_\_\_\_\_

**Drivers License Number will be asked for to verify identity when calling to make alternate pick-up arrangements for your child.**

Email address we may use to contact you \_\_\_\_\_

How did you hear about us or whom may we thank for referring you? \_\_\_\_\_

The following people are allowed to pick up my child at any time:

\_\_\_\_\_

In case of accident or emergency, notify these people in this order:

1. \_\_\_\_\_  
Name Relation to Child Phone

2. \_\_\_\_\_  
Name Relation to Child Phone

3. \_\_\_\_\_  
Name Relation to Child Phone

Are you currently attending a church? Yes No If so, where? \_\_\_\_\_

# EMERGENCY MEDICAL CARE PERMIT

In the event that I cannot be reached to make arrangements for medical care, I hereby give permission for the staff at 1st Kids Academy to authorize any necessary emergency medical treatment for my child.

Child's Name \_\_\_\_\_ Date \_\_\_\_\_

Parents Signature \_\_\_\_\_

## MEDICAL INFORMATION:

List all drug allergies each child may have \_\_\_\_\_

List all medications each child may be taking \_\_\_\_\_

List all environmental allergies each child may have (i.e., ant bites, pollen, etc.)

\_\_\_\_\_

List all food allergies each child may have \_\_\_\_\_

Doctor's Name \_\_\_\_\_

Doctor's Phone Number \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Policy or Social Security Number \_\_\_\_\_ Name of Insured \_\_\_\_\_

Is there anything else about your child/children we need to know?

\_\_\_\_\_

\_\_\_\_\_

1<sup>st</sup> Kids Academy has my permission to use my child's picture and/or video on its website or for advertising purposes.

Please circle one: YES or NO

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

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For Office Use Only:

Date Reg. Rec'd. \_\_\_\_\_

Registration Amount \$ \_\_\_\_\_

Pre-K Curriculum \_\_\_\_\_

Registration Check # \_\_\_\_\_

Room Number # \_\_\_\_\_