IndianRocks CHRISTIAN SCHOOL

PRESCHOOL ENROLLMENT RECORD

Age: K2 K3 K4

DIRECTOR'S USE ONLY

Date enrolled _____

Child's full legal name _____
First *Middle* *Last*

Sex _____ **Birth Date** _____

Child's preferred name/nickname _____ **Ethnicity** _____

Address _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Primary hours child will be in the children's center Half Day 8:15-11:30 OR Full Day 8:15-3:00

Days of week child will be in the children's center Monday through Friday (5 days per week)

Who has legal custody _____ Relationship to student _____

Address _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Home Phone _____ Cell Phone _____

Parent's Name Title: Mr. Mrs. Miss Dr. Pastor _____ D.O.B. _____

Home Phone _____ Cell Phone _____

Home Address _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Place of Employment _____

Address of Employer _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Telephone _____ Email _____

Parent's Name Title: Mr. Mrs. Miss Dr. Pastor _____ D.O.B. _____

Home Phone _____ Cell Phone _____

Home Address _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Place of Employment _____

Address of Employer _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Telephone _____ Email _____

The child will be released only to the person(s) authorized, or in the manner authorized, in writing, by the custodial parent(s) or legal guardian(s). The following person must be someone other than the custodial parent(s) or legal guardian(s) and is authorized to remove the child from the facility in case of illness, accident, or emergency, **if for some reason the custodial parent(s) or legal guardian(s) cannot be reached:**

Name _____ Relationship to Student _____

Home Phone _____ Cell Phone _____

Home Address _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Name _____ Relationship to Student _____

Home Phone _____ Cell Phone _____

Home Address _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

CONTINUED ON BACK

CHILD'S ENROLLMENT RECORD
(Back Page)

Child's Physician/Health Resource _____

Telephone Number _____

Address _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Hospital Preference _____

Name of Dentist _____Telephone _____

Address _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Medical Insurance Co. Name _____ Policy# _____ Group# _____

MISCELLANEOUS INFORMATION

List all known allergies _____

_____

List all identifying scars, birthmarks, skin discolorations _____

Special medical or dietary needs of child _____

_____

List any areas of concern _____

_____

My signature below verifies that:
I give permission to consult the child's physician/health resource listed above in case of emergency if parent/guardian cannot be reached.

I have received a copy of the "Know Your Child's Children's Center" brochure, and a copy of the children's center discipline policy.

I was notified that the snacks/meals served daily are: ☐Breakfast ☐AM Snack ☐Lunch ☐PM Snack ☐Dinner

Presentation of false information or omission of pertinent information on this application and/or during an interview will constitute grounds for dismissal from Indian Rocks Christian School with no refund of tuition or fees.

I verify that the information on this enrollment form is complete and accurate.

_____ _____
Signature of Custodial Parent or Legal Guardian **Date**