

Enrollment Application

			Date	of Birth:	
Enrollment Date:	Sex: M	F	Child's las	t 4 digits of SS#:	
Home Address:					_
Home Ph#:				circle) From to	
Mother's Name:		Driver's	License Number		_
Cell Phone Number		_ Cell Phone Pro	vider		
Place of Employment:					
Father's Name:		Driver's I	icense Number _		
Cell Phone Number		_ Cell Phone Pro	vider		
Place of Employment:					_
Parent's marital status: S N	M D W		Child lives with: _		_
The Child may be released to the	e following people v	with proper identi	fication:		
Name:	Pho	one:	Rel	ation:	
	Ado	dress:			
Name				ation:	
Name:					
Name:		one:	Rel	ation:	
Name:List any allergies or special need	Pholes your child may ha	ave:			
Name:	Pholes your child may have a second of the s	ON for EMERGI	ENCY MEDICAL eachers of Kids R	ATTENTION: Kids 11tx to take my child to):
Name:	Pholes your child may hat I US?? AUTHORIZATI hed, I authorize the	ON for EMERGI	ENCY MEDICAL eachers of Kids R	ATTENTION: Kids 11tx to take my child to	- - :
Name:	Pholes your child may have a second of the s	ON for EMERGI	ENCY MEDICAL eachers of Kids R Phone: Fax: _	ATTENTION: Kids 11tx to take my child to	- - D:
Name:List any allergies or special need HOW DID YOU HEAR ABOU' In the event that I cannot be reac Name of Physician:Address:Name of Hospital or Clinic:	Pholes your child may have a second of the s	ON for EMERGI management or t	ENCY MEDICAL eachers of Kids R Phone: Fax: Phone:	ATTENTION: Kids 11tx to take my child to	D:
Name:	Pholes your child may have a second of the s	ON for EMERGI management or t	ENCY MEDICAL eachers of Kids R Phone: Fax: Phone:	ATTENTION: Kids 11tx to take my child to	D:
Name: List any allergies or special need HOW DID YOU HEAR ABOU' In the event that I cannot be reac Name of Physician: Address: Name of Hospital or Clinic: Parent/Guardian signature:	Pholes your child may have a second of the s	ON for EMERGI	ENCY MEDICAL eachers of Kids R Phone: Fax: Phone:	ATTENTION: Kids 11tx to take my child to 281-274-7000	D:
Name: List any allergies or special need HOW DID YOU HEAR ABOUT In the event that I cannot be reach Name of Physician: Address: Name of Hospital or Clinic: Parent/Guardian signature: Transportation: I give or and and are and are and are are and are	Pholos your child may hat I US??	ON for EMERGI management or t	ENCY MEDICAL eachers of Kids R Phone: Fax: Phone: D child to be transpo	ATTENTION: Kids 11tx to take my child to 281-274-7000 Date: orted on:	D:
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Parent's signature: