



Physician:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\*A medical form, provided by the Center, is due upon enrollment of your child.\*

Health:

Does your child have frequent colds, illnesses etc? \_\_\_\_\_

Has your child had any serious illness, operations or accidents (that we need to be aware of)?

Siblings and ages:

Please list anyone else who lives in your home or spends a significant amount of time with your child: \_\_\_\_\_

Do you have internet access? \_\_\_\_\_yes \_\_\_\_\_no

Your email address: \_\_\_\_\_

May we publish your name and address in our Center directory?

\_\_\_\_\_yes \_\_\_\_\_no

May we take and utilize pictures of your child for Center publicity?

\_\_\_\_\_yes \_\_\_\_\_no

I give consent to the staff at Open Arms Christian Child Development Center to seek medical attention or aid for my child as deemed necessary by a duly licensed or recognized physician or surgeon in case of an emergency when the parents cannot be reached.

\_\_\_\_\_yes \_\_\_\_\_no

Consent is also given to transport my child if emergency medical treatment is needed.

\_\_\_\_\_yes \_\_\_\_\_no

Authorization: Person(s) authorized to take your child from the center:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

\*If we have not met the person we will ask for identification. Please be sure they know to bring their driver's license.\*

Church Membership at: \_\_\_\_\_ Denomination: \_\_\_\_\_

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