Registration Form

FOR OFFICE USE ONLY
Enrollment Date______________
Pd $_______ Credit
Debit Cash
Check #___________
Cash Receipt #________
6:30am – 6pm
6:30am – 3:30pm
Daily
After School_________

PLEASE PRINT

Child's Full Name________________________________ Age____ Date of Birth____________ Sex___

Child's Nickname_____________ Child's Address____

Who does the child live with? Father Mother Both Father & Mother Other_________

Parent/Guardian Information:

Mother/Guardian Full Name____

Father/Guardian Full Name____

Address____________________________________ Address _______________________________________

City______________________ State___ Zip_______ City______________________ State___ Zip_________

Mother/Guardian Home #___________________ Father/Guardian Home #______________________

Mother/Guardian Cell#______________________ Father/Guardian Cell#_________________________

Mother/Guardian Work#____________________ Father/Guardian Work#________________________

Email Home________________________________ Email Home___________________________________

Email Work________________________________ Email Work____________________________________

Person(s) authorized to pick up child or to call in an emergency:
Please list who may be contacted in case we cannot reach the parent.

(1) Name______________________________ Address____

Relationship to child____________ Home Phone____________ Work Phone___________ Cell Phone_____________

(2) Name______________________________ Address____

Relationship to child____________ Home Phone____________ Work Phone___________ Cell Phone_____________

(3) Name______________________________ Address____

Relationship to child____________ Home Phone____________ Work Phone___________ Cell Phone_____________

(4) Name______________________________ Address____

Relationship to child____________ Home Phone____________ Work Phone___________ Cell Phone_____________

REGISTRATION (CONT)

Persons in your household:
Please list the names and relationships to the child of all persons living in the child's household.

Name	Date of Birth	Relationship

YOUR CHILD'S HEALTH QUESTIONAIRE

List any known allergies to food or the environment.

____

What is their allergic reaction?

____

What other medical or other things should we know about your child?

____

____

Child's Physician: ______________________________ **Phone #:**_____________

Child's Dentist: ________________________________ **Phone#:**_____________

Preferred Hospital: ____

Health Insurance Provider______________________________ **Policy/Group #**_________________

I authorize Miracles Learning Center to seek professional medical treatment for my child in case of serious illness or injury and neither I nor any of our listed contacts can be reached. I also agree to pay for this treatment.

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Signature of Parent/Guardian **Date**

I release Miracles Learning Center (MLC) from any and all liabilities due to injury while participating in MLC programs on the MLC campus, or while on MLC field trips along with any other MLC affiliated activities.

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Signature of Parent/Guardian **Date**