

# First Christian Church Mother's Day Out Registration

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

Date of Birth \_\_\_\_\_ Known Allergies \_\_\_\_\_

Home Address (include zip code) \_\_\_\_\_  
\_\_\_\_\_

Parent's Name(s)/ Guardian \_\_\_\_\_

Email Address \_\_\_\_\_

Mom Cell \_\_\_\_\_ Dad Cell \_\_\_\_\_ Home Phone \_\_\_\_\_

Employer Information: Father \_\_\_\_\_ Phone \_\_\_\_\_

Mother \_\_\_\_\_ Phone \_\_\_\_\_

Church Membership \_\_\_\_\_

Please, list the name, number and relationship of those authorized to pick up your child. These names will also be used for contact in the case of emergency if we are NOT able to reach a parent / guardian. We will ask for I.D. if we are not familiar with the individual.

	Name	Relationship	Phone Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Additional Comments \_\_\_\_\_  
\_\_\_\_\_

Mother's Day Out has permission to put my child's picture on Facebook or in the newspaper.  
Yes \_\_\_\_\_ No \_\_\_\_\_

Mother's Day Out has permission to share my information with the leadership of FCC Belleville.  
Yes \_\_\_\_\_ No \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

## Office Use Only:

Date Registration Paid \_\_\_\_\_

Forms Submitted: Registration \_\_\_\_\_ Teacher Info Sheet \_\_\_\_\_ Physical \_\_\_\_\_ Date of Physical \_\_\_\_\_

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State of Illinois  
Department of Children and Family Services

Name of Child \_\_\_\_\_

Parents or guardian placing the child may sign any or all of the following consents:

## EMERGENCY MEDICAL CARE:

This authorizes Mother's Day Out, First Christian Church, to secure EMERGENCY medical care for my child when I/we cannot be immediately reached at the time of emergency. I/we will be responsible for the emergency medical charges upon receipt of the statement.

\_\_\_\_\_ is the preferred doctor/clinic/ hospital.

Date \_\_\_\_\_ Signature of parent /guardian \_\_\_\_\_

Relationship to child \_\_\_\_\_

## ADMINISTER PRESCRIPTION MEDICINE :

This authorizes Mother's Day Out, First Christian Church, to administer prescribed medicine to my child as specified in written instructions.

Date \_\_\_\_\_ Signature of parent / guardian \_\_\_\_\_

Relationship to child \_\_\_\_\_

## ADMINISTER PATENT (NON-PRESCRIPTION/OVER THE COUNTER) MEDICINE:

This authorizes Mother's Day Out, First Christian Church, to administer patent medicine to my child as specified in written instructions.

Date \_\_\_\_\_ Signature of parent / guardian \_\_\_\_\_

Relationship to child \_\_\_\_\_