



Christ's Little Acorns After School program

OFFICE REVISIONS

Date: _____ Note: _____

Date: _____ Note: _____

Date: _____ Note: _____

2018-2019 Registration Form

PARENTS PLEASE FILL OUT

Grade: _____ School your child attends: _____

**REGISTRATION FEE IS
NON-REFUNDABLE**

**MAKE CHECKS
PAYABLE TO CUMC**

Child's Personal Information

Child's Name: _____ (_____)

Address: _____
Street or P.O. Box _____ City _____ Zip Code _____

Home Phone: _____ Birthday: ____/____/____ Male Female

Child Lives With: (circle) Both Parents Mother Father Grandparents Guardian Other _____

Who is responsible for payments? _____ Phone #: _____ Email: _____

Mother's Information

Mother's Name: _____

Address: _____

Mother's Workplace: _____

Mother's Work Phone: _____

Mother's Cell: _____

Permission to Text? Yes or No

Mobile Carrier: _____

Can Mom pick up? Yes or No

Mother's email: _____

Father's Information

Father's Name: _____

Address: _____

Father's Workplace: _____

Father's Work Phone: _____

Father's Cell: _____

Permission to Text? Yes or No

Mobile Carrier: _____

Can Dad pick up? Yes or No

Father's email: _____

Transportation Provided for Child

Person (s) responsible for pickup & delivery of your child. Anyone not listed will not be permitted to pick up your child. Also, please indicate if they may be used as an emergency contact. **Mom and Dad are assumed unless otherwise noted.**

1. _____ Relationship: _____ Phone: _____
2. _____ Relationship: _____ Phone: _____
3. _____ Relationship: _____ Phone: _____
4. _____ Relationship: _____ Phone: _____
5. _____ Relationship: _____ Phone: _____

Is there anyone who can **NOT** pick up your child? _____

Are there custody issues we need to be aware of? _____

OFFICE INFO ONLY

CLASS: _____ TEACHER: _____ PHOTO RESTRICTIONS: Y OR N ALLERGIES: N OR Y: _____

REG. FEE: \$ _____ REG. FEE PAID: _____ CASH ONLINE CK# _____ START DATE: _____ DISCOUNTS: _____

We use email and text messaging to communicate with our parents regarding closings, special events and reminders. Please list below anyone else who would benefit from receiving these messages.

Name: _____ Email: _____ Cell: _____ Mobile Carrier: _____
Name: _____ Email: _____ Cell: _____ Mobile Carrier: _____
Name: _____ Email: _____ Cell: _____ Mobile Carrier: _____

Important Information:

Health issues or special needs: _____

Does your child take daily medication at home? Y or N Name of medication(s): _____

What dosage? _____ How often? _____

Prescribed by whom: _____ Purpose of medication: _____

Does your child have allergies to the following? (please check all that apply)

Bee Stings Food Allergies Asthma Other

Does your child have an epipen?: _____

Photo, Video & Social Media Release:

The preschool **will** use pictures & videos of your child throughout the year for, crafts, bulletin boards and take home gifts. Our **social media policy** is that children are never identified in photos by name.

I **DO** give permission for Christ's Little Acorns Preschool to use pictures/videos of my child in promotional materials and Christ's Little Acorns' website and social media.

I **DO NOT** give permission for Christ's Little Acorns Preschool to use pictures/videos of my child in promotional materials and Christ's Little Acorns' website and social media.

Medical Information:

*Please provide a copy of your child's immunization records & completed health form for our files. If your child is exempt from immunizations, please see office for appropriate forms.

Does your child have medical insurance? _____ YES _____ NO

Name of Medical Insurance Carrier: _____

Policy/Group Number: _____

Are there any special activities that are limited by physician's advice? _____

If yes, please explain: _____

Authorization for Emergency Medical Care

In case of an accident or illness requiring medical attention, the undersigned authorize Christ's Little Acorns Preschool to call a health care provider to take my child, _____ to the nearest hospital or doctor.

Doctor: _____ Phone: _____
Dentist: _____ Phone: _____
Hospital preference: _____ Phone: _____

It is understood that if possible, these services will be obtained. If parents or preferred healthcare provider cannot be contacted, the preschool is authorized to contact another health care provider. It is also understood that this agreement covers only those situations which, in the best judgment of the preschool, are true emergencies. I agree to be responsible for the cost of such emergency medical care.

Parent/Guardian's Signature _____ Date _____

CONTACT INFORMATION:

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