Golden Rule
Matthew 7:12 Christian Pre-School

Registration Form

Child's Name: _____ Date: _____

Date of Birth:_____/_____/_____ Male ❑ Female ❑

Street Address: _____ City:_____ Zip:_____

Home Phone: _____ Parent Cell 1:_____ Parent Cell 2: _____

Parent's Name: _____

E-mail: _____

Child lives with (check all that apply);

Mother & Father ❑ Mother ❑ Father ❑ Other:_____

Mother's Occupation: _____ Work Number: _____

Father's Occupation: _____ Work Number: _____

Doctor: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Alternate Contact: _____ Phone: _____

Health Comments: _____

Has your child ever attended PreSchool? Yes ❑ No ❑ If yes, where? _____

Church Affiliation: _____

My child may be picked up by:

Name: _____Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

Photograph Permission:

I give permission to Golden Rule Christian School to photograph my child during school and/or day care activities.

I accept ❑ I decline ❑

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Emergency Contact

Child's Name: _____ Age: _____ Birth Date: _____

Address: _____ Home Phone: _____

City:_____ State: _____ Zip Code: _____

Parent/Guardian Name (Mother):_____ Cell: _____

Place of Employment: _____

Address: _____Phone: _____

City:_____ State: _____ Zip Code: _____

E-mail: _____

Parent/Guardian Name (Father):_____ Cell: _____

Place of Employment: _____

Address: _____Phone: _____

City:_____ State: _____ Zip Code: _____

E-mail: _____

Doctor: _____ Phone: _____

Is your child allergic to foods, medicine, or insect stings/bites? _____

**If yes, please provide a list of all allergies*

EMERGENCY CONTACTS – Other than parents:

Name: _____ Relationship: _____ Phone: _____

MEDICAL RELEASE FORM – *In the event of a medical emergency involving my child*

Print Child's Name: _____

I understand that Golden Rule Christian School will make every effort to contact me in the event of a medical emergency involving my child. If the school cannot reach me, I give permission for the school to seek medical attention for my child. Any medical fees incurred will be my responsibility. I agree to hold harmless Golden Rule Christian School and Solitude Baptist Church for their actions on my behalf.

Parent: _____ Date: _____

Child Medical Report

Child's Name: _____ Date of Birth: _____

Name of Child's Parent or Guardian: _____

Address: _____ Telephone Number: _____

In addition to a medical report or medical screening a Certificate of Immunization (ADPH-F-I MM-50) is required for each child two months to five years of age and for five-year-olds who are not enrolled in public or private school.

History of Allergies:

_____

_____

_____

_____

I examined this child on (date)_____. I find him her to be in good physical condition and free or contagious and infectious diseases except as noted below.

_____

_____

_____

_____

_____

Signature of Physician, Physician's Assistant, Certified Nurse Practitioner

_____

Date