Golden Rule
Matthew 7:12 Christian Pre-School

Registration Form

Child's Name: _____ **Date:** _____

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

Address: _____ Home Phone: _____

City:_____ State: _____ Zip Code: _____

Child lives with (check all that apply);

Mother & Father ❑ Mother ❑ Father ❑ Other:_____

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

Place of Employment: _____ Phone: _____

E-mail: _____

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

Place of Employment: _____ Phone: _____

E-mail: _____

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

Church Affiliation: _____

Emergency Contacts/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 ❑

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:** _____

Doctor: _____ Phone: _____

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

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

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