God's Garden Preschool
A Ministry of First Baptist Church of Dover
Child Enrollment Form

CHILD'S NAME: _____ DATE ENROLLED: _____
(First) (Middle) (Last) mm/dd/yyyy

CHILD'S PREFERRED NAME: _____ BIRTH DATE: _____
mm/dd/yyyy

ADDRESS: _____ CITY/STATE: _____ ZIP:_____

MOTHER'S NAME:	FATHER'S NAME:
ADDRESS:	ADDRESS:
HOME PHONE:	HOME PHONE:
EMPLOYER:	EMPLOYER:
WORK PHONE:	WORK PHONE:
CELL PHONE:	CELL PHONE:
E-MAIL:	E-MAIL:

EMERGENCY INFORMATION

PERSONS AUTHORIZED TO PICK UP CHILD: Mother: Yes _____ No_____ Legal custody: Yes _____ No____
Father: Yes _____ No_____ Legal custody: Yes _____ No____

EMERGENCY CONTACTS/OTHER PERSONS AUTHORIZED TO PICK UP CHILD (LEGAL ID REQUIRED):

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

MEDICAL INFORMATION

CHILD'S DOCTOR: _____ DOCTOR'S PHONE: _____

PREFERRED HOSPITAL: _____

ALLERGIES/MEDICAL CONDITIONS/SPECIAL NEEDS: _____

_____

ADDITIONAL INFORMATION WHICH WOULD BE HELPFUL FOR THE PRESCHOOL TO KNOW ABOUT YOUR CHILD: _____

_____

FAMILY INFORMATION

IS CHILD LIVING WITH MOTHER? ____ FATHER? ____ STEP-PARENT (MOTHER OR FATHER)? _____

CHILD'S SIBLINGS-

NAME: _____ AGE: _____ NAME: _____ AGE: _____

NAME: _____ AGE: _____ NAME: _____ AGE: _____

LANGUAGE SPOKEN AT HOME: _____

NAME OF CHURCH YOU ATTEND? _____

WOULD YOU LIKE TO RECEIVE INFORMATION ABOUT OUR CHURCH MINISTRIES? _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

If my child, _____, should become ill or injured at, **God's Garden Preschool**, I understand that the staff will (1) Contact me immediately and (2) Contact the person I have designated if I cannot be reached.

Should the facility be unable to reach me or the person I have designated, they are authorized to contact my child's physician and/or arrange for immediate medical treatment.

The physician and/or medical facility are authorized to administer emergency medical treatment necessary to ensure the health and safety of my child.

I will accept responsibility for payment of medical services rendered.

_____

SIGNATURE RELATIONSHIP DATE

ACKNOWLEDGEMENT OF RECEIPT OF FORMS

HILLSBOROUGH COUNTY ORDINANCE requires that parents must receive a copy of the "KNOW YOUR CHILD CARE FACILITY BROCHURE", information on the INFLUENZA (FLU) VIRUS and that parents are notified in writing of "DISCIPLINARY PRACTICES" used by the Child Care Facility. The parent's signature certifies receipt of the Child Care Facility brochure, influenza information, discipline policies, and that all the information on this form is true and accurate.

_____ _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE