

**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