

# Summer S'Cool / Children's Day Out

## Enrollment Form

### *Child's information*

Child's name \_\_\_\_\_

First

Middle

Last

Name usually called

Home address \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Home phone \_\_\_\_\_

Sex: M\_\_\_ F\_\_\_

Birthdate \_\_\_\_\_

**ALLERGIES** \_\_\_\_\_

Are there any special needs, concerns, illnesses, health problems or situations that might affect your child's day in CDO? \_\_\_\_\_  
\_\_\_\_\_

### *Parents' Information*

#### Mother

Name \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Place of employment \_\_\_\_\_

Work phone \_\_\_\_\_

#### Father

Name \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Place of employment \_\_\_\_\_

Work phone \_\_\_\_\_

## Persons Authorized to Pick Child Up

Name \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Cell phone \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Cell phone \_\_\_\_\_

## Medical Release and Photo Consent

I hereby release and agree to hold harmless McFarlin Memorial United Methodist Church and its staff from any and all liability associated with the medical care and treatment of my child by a qualified health care provider. I further authorize, in case of emergency, accident or medical crisis involving my child, McFarlin Memorial Untied Methodist Church and its staff to transport and authorize for the treatment of my child any and all care necessary, determined by an authorized/qualified health care provider in my absence while my child is under the custody, care and control of McFarlin Memorial Untied Methodist Church.

I also, give permission for the videotapes and/or photographs of my child to be used by McFarlin Memorial United Methodist Church for the purpose of identification, education or promotion in both internal/external publications.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Medical Information

Child's Physician \_\_\_\_\_

Physician's address \_\_\_\_\_

Physician's phone \_\_\_\_\_

Insurance company name \_\_\_\_\_

Telephone number \_\_\_\_\_

Policy number/Group number \_\_\_\_\_

Name of primary insured \_\_\_\_\_

**\*\*Attach a copy of your child's current immunization record\*\***