

JOURNEY

REGISTRATION FORM

DATE OF ENROLLMENT: _____

(Child's "Start Date")

CHILD'S NAME: _____ SEX: M F
First Last Middle Nickname

ADDRESS: _____ DATE OF BIRTH: _____ AGE: _____
CITY: _____ STATE: _____ ZIP: _____ PHONE: _____

FATHER/GUARDIAN INFO:

NAME: _____

ADDRESS: (If different from above) _____

EMPLOYER: _____

ADDRESS: _____

OCCUPATION: _____

HOURS AVAILABLE AT WORK: _____

WORK PHONE: _____

CELL PHONE: _____

EMAIL: _____

Parent we should contact first for illness or injury: _____

Special instruction as to how we may reach you while your child is at our center: _____

MOTHER/GUARDIAN INFO:

NAME: _____

ADDRESS: (If different from above) _____

EMPLOYER: _____

ADDRESS: _____

OCCUPATION: _____

HOURS AVAILABLE AT WORK: _____

WORK PHONE: _____

CELL PHONE: _____

EMAIL: _____

PERSONS AUTHORIZED TO PICK UP YOUR CHILD:

NAME: _____

ADDRESS: _____

PHONE: _____ CELL: _____

NAME: _____

ADDRESS: _____

PHONE: _____ CELL: _____

PERSONS WHO CAN ASSUME RESPONSIBILITY IN THE EVENT OF AN EMERGENCY IF YOU CANNOT BE REACHED IMMEDIATELY:

NAME: _____

ADDRESS: _____

PHONE: _____ CELL: _____

NAME: _____

ADDRESS: _____

PHONE: _____ CELL: _____

The above information that has been provided is correct to best of my knowledge. I understand the information on this document is used only for purposes necessary for Journey Christian ELC and will be held in confidentiality.

Parent/Guardian Signature

Date

OFFICE USE: Registration: _____ Immunization: _____ Payment/fees: _____ Enrollment forms: _____
ENROLLMENT/SESSION: AM PM Please circle days: M/W/F T/TH Other: _____
FULL DAY: M T W TH F Hours expected to attend: _____

CHILD INFORMATION

What are your child's areas of strength? _____
What are your child's areas of need? _____
What are your child's likes or interest? _____
Does your child have any behavioral/developmental concerns? _____
Is your child toilet trained? _____ Partially _____ Completely _____
How does your child ask to go to the bathroom? _____
Does your child rest or sleep in the afternoon? _____

HEALTH INFORMATION

Does your child have any known allergies? _____
If "yes" does he/she have an EpiPen? _____
List medication your child is currently taking? _____
Type, dose, times administered, possible side effects _____
Any medical diagnosis? If yes, please explain. _____
Has your child had any serious childhood illnesses or accidents? _____
Is your child prone to or has he/she ever had seizures? _____
Is there a history of chronic ear infections or have tubes in ears? _____
Any specific medical problems or physically limiting disorders? _____

FAMILY INFORMATION

With whom is the child currently living? _____
If separated/divorced, what are the visitation arrangements for your child? _____
Is child adopted? _____ If so, at what age? _____

Sibling(s), step-sibling(s), half-siblings(s):

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

What activities do you share with your child? (Stories, meals, play, etc.) _____

Does your child speak another language other than English? _____

Is there any information you would like to share about your child's cultural background, religion, family traditions, or unique holiday traditions? _____

Please describe any accommodations that will be needed for your child to feel comfortable and for your beliefs to be respected in the classroom: _____

PLEASE COMPLETE AND ATTATCH A COPY OF CHILD'S IMMUNIZATION RECORDS