

## Kid's Corner Registration Form

Name of Child \_\_\_\_\_ Date \_\_\_\_\_

Teacher \_\_\_\_\_ House \_\_\_\_\_ Grade \_\_\_\_\_

School \_\_\_\_\_ Bus # \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

### **Parent or Guardian:**

Name of Father \_\_\_\_\_ Home Phone \_\_\_\_\_

Password \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Address \_\_\_\_\_

Employed By \_\_\_\_\_ Work Phone \_\_\_\_\_

Name of Mother \_\_\_\_\_ Home Phone \_\_\_\_\_

Password \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Address \_\_\_\_\_

Employed By \_\_\_\_\_ Work Phone \_\_\_\_\_

Child lives with: Father \_\_\_\_\_ Mother \_\_\_\_\_ Both \_\_\_\_\_ Other \_\_\_\_\_

### **EMERGENCY CONTACTS and Others who may pick up my child(ren):**

1. Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

2. Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

3. Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

**\*\*NOTE: Your password is necessary for security – to identify that you are the parent when you call for your child.**

Please share any additional information that you feel would be useful in providing for your child's needs/health concerns \_\_\_\_\_

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**e-mail Address** \_\_\_\_\_

# Emergency Medical Information

Child's Name: \_\_\_\_\_

Child's Medical Condition:

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

Address \_\_\_\_\_

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Office Number \_\_\_\_\_ Other # \_\_\_\_\_

Health Insurance Info:

Insurance Co. \_\_\_\_\_ Policy ID # \_\_\_\_\_

Policy Holder \_\_\_\_\_

Please be advised that during Kid's Corner hours of operation there may not be a nurse in the building. Kid's Corner personnel can not administer medications to any student. In case of a serious emergency Kid's Corner personnel will call 911. If emergency medical care is deemed necessary and I cannot be contacted I authorize the program staff to act on my behalf in granting permission for my child to receive emergency treatment. I understand that in a severe emergency, my Child will be taken by ambulance to the nearest hospital.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date