

**Westminster Children's Weekday Ministries
(Preschool, Before & Afterschool, PEC, Summer)
Registration Form**

Office Use:
Date Received _____
Received by: _____
Total Paid: _____
Activity Fee: _____

Child's full name:

_____ (Last) (First) (Middle) (Nickname)

Date of Birth: ____/____/____ M / F Grade/Age as of the Sept 1 ____ Home Phone: (____) _____

Home Address: _____
(Street Address) (City) (zip code)

Who has legal custody of this child? (Circle all of the following that apply)

Mother father stepmother stepfather grandparent Other: _____

List family members with whom child lives, and their relationship to this child:

(Name/(Relationship)) _____

<p>Mother/Guardian's Name:</p> <p>_____</p> <p>Address (if different from child's):</p> <p>_____</p> <p>_____</p> <p>Home Phone (if different from child's):</p> <p>_____</p> <p>Mother's Employer: _____</p> <p>Work phone: _____</p> <p>Cell phone: _____</p>
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<p>Father/Guardian's Name:</p> <p>_____</p> <p>Address (if different from child's):</p> <p>_____</p> <p>_____</p> <p>Home Phone (if different from child's):</p> <p>_____</p> <p>Father's Employer: _____</p> <p>Work phone: _____</p> <p>Cell phone: _____</p>
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Emergency Contact/Pick Up Authorization

List names phone numbers and addresses:

Name: _____
Address: _____
Phone: _____

Name: _____
Address: _____
Phone: _____

Name: _____
Address: _____
Phone: _____

Name: _____
Address: _____
Phone: _____

If there is a noncustodial parent who is not authorized to pick up your child, list their name & description below:

If space is unavailable when you register, do you wish to be placed on our waiting list? Registration fee will be returned to you if this occurs, payable when a space becomes available. Waiting list: Yes No

Westminster Children's Weekday Ministries
(Preschool, Before & Afterschool, PEC, Summer)
Medical Information & Authorization for Treatment

Child's full name: _____
(Last) (First) (Middle)

Date of birth: ____/____/____ M / F Home Phone # _____

Mother/Guardian's Name: _____ Mother's Employer: _____ Work phone: _____ Cell phone: _____

Father/ Guardian's Name: _____ Father's Employer: _____ Work phone: _____ Cell phone: _____
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Please Check all that apply and give a brief explanation:

- Allergies to foods, medications, etc. _____
- Special current/recurrent illness _____
- Any known medical conditions _____
- Diagnosed learning or behavior disability _____
- Physical or Speech Therapy _____
- Other _____

All the above information provided is accurate and complete to my current knowledge. If any additional information is to be provided must be in written notice form.

(Parent's Signature & Date)

Child's primary physician: _____ Phone # (____) _____

Name of health insurance company: _____

Group and/ or Policy #: _____

Name on Policy: _____

Insurance company phone # to verify coverage: _____

Should my child, (Full name) _____ suffer an injury or illness while in the care of Westminster Children's Weekday Ministries of WPC, and the facility is unable to contact me immediately, or delay of treatment would be dangerous to my child, I authorize Westminster Children's Weekday Ministries of WPC to secure such medical attention and care of my child as may be necessary, including emergency services at Eastside Medical Center, in Snellville, GA. I shall assume responsibility for payment of services.

Parent / Guardian Signature: _____

Date ____/____/____

Print Name: _____

Relationship: _____