Child's application

Full Name of Child: _____ Start Date: _____

Child's DOB: _____ Male ☐ Female ☐ Goes by name: _____

Parents/Custodial Parents

Mother's Name: _____ Father's Name: _____

Mother's Email: _____ Father's Email: _____

Home Address: _____ Home Address: _____

_____ _____ _____ _____ _____ _____

City State Zip City State Zip

Cell Phone: _____ Cell Phone: _____

Work Phone: _____ Work Phone _____

Employer: _____ Employer: _____

Work Address: _____ Work Address _____

_____ _____ _____ _____ _____ _____

City State Zip City State Zip

Work Hours: _____ Work Hours: _____

Marital Status: _____ Marital Status: _____

Are both mother & father involved in the child's life? Yes ☐ No ☐

If no, explain circumstances: _____

What time do you plan to drop off _____ pick up? _____

Prior school attended _____

Do you attend Calvary Chapel Chattanooga? Yes ☐ No ☐

Emergency Contacts and Persons Authorized to Pick up Student

Name of persons authorized to pick up child or contact if parents are unavailable.

1. _____ Relationship to Chid _____

Cell Phone _____ Work Phone _____

2. _____ Relationship to Chid _____

Cell Phone _____ Work Phone _____

3. _____ Relationship to Chid _____

Cell Phone _____ Work Phone _____

Physician Contact Information

Name of Physician: Phone:

Address:

City State Zip

Ongoing Medical Care

Does the child have any medical diagnosis that requires ongoing care? If yes, explain what type of care is administered at home and by whom?

Are you requesting that this care be provided by F.P.A.? If yes, describe the care required

(Please request a doctor's statement for any specified requests for care at the facility.)

Consent for Emergency Medical Treatment

As the parent or authorized representative, I hereby give consent to Foundations Preschool &

Academy to obtain all emergency medical or dental care prescribed by a duly licensed Physician

(M.D.) Osteopath (D.O.) or Dentist (D.D.S.) for _____

(Child's Name)

This care may be given under whatever conditions are necessary to preserve the life or limb of

the child named above.

_____ _____

Parent Signature Date

Electronic print serves as your signature

*PLEASE READ COMPLETELY BEFORE SIGNING

My child _____ is allergic to the following

_____

_____

_____

Parent's Signature

Electronic print serves as your signature

My child _____ has NO allergies that I am aware of

(Child's Name)

_____

Parent's Signature

Electronic print serves as your signature