

Blaine Church School Registration Form

Child's Name: _____

Primary Daytime Phone: (____) _____

Grade in Fall: _____ **School:** _____

Email: _____

Would you like to be included in email reminders/notices? YES _____ NO _____

Child Info: Age: _____ Gender: _____

Birthdate: _____

Street Address: _____ City: _____ Zip: _____

Home Phone: (____) _____

Child Lives With: _____

Parent/Guardian Info:

Parent/Guardian Name: _____ Cell Phone: (____) _____

Work Place: _____ Work Phone: (____) _____

Work Address: _____ City: _____ Zip: _____

Parent/Guardian Name: _____ Cell Phone: (____) _____

Work Place: _____ Work Phone: (____) _____

Work Address: _____ City: _____ Zip: _____

Emergency Contact (other than parents or doctor): _____ Phone: (____) _____

Out of Area Emergency Contact: _____ Phone: (____) _____

List all persons, (other than both parents) authorized to pick up, sign-in or out child (including any youth that might give your youth a ride):

Name, Address, Phone, Relationship to Child

1. _____ (____) _____
2. _____ (____) _____
3. _____ (____) _____
4. _____ (____) _____
5. _____ (____) _____

Insurance: It is the responsibility of every individual, their parent or legal guardian, to provide for their own accident and health coverage while participating in all Blaine Church School activities.

Child's Physician: _____ Phone : (____) _____

Address: _____ City: _____ Zip: _____

Medical Insurance Company: _____ Policy Number: _____

Date of last physical exam: _____ **Date of last tetanus shot:** _____

Child's Dentist/Orthodontist: _____ Phone: (____) _____

Blaine Memorial United Methodist Church strives to provide the best care possible, and being prepared for your child's needs will help your child adjust to the program.

IDENTIFY ANY SPECIFIC MEDICAL, BEHAVIORAL OR DEVELOPMENTAL NEEDS OF YOUR CHILD.

Failure to share information that identifies your child's special care, accommodations or supervision needs may jeopardize the placement of or continued participation by your child in the program.

Request Description of Medical and/or Special Needs form to provide further information.

- Dietary modifications/allergies: _____
- Chronic/recurring illness: _____
- Current medications: (fill out medication form) _____
- Operations/serious injury: _____
- Physical disability: _____
- Behavioral disorder: _____
- Developmental delay: _____

IMPORTANT: Please notify staff if your child is exposed to any communicable diseases during attendance, including scabies & head lice.

- Has your child had any previous group experiences? (co-ops, preschool, child care, etc.) _____
_____ What was your child's response? _____
- Child responds best to _____
- Child responds poorly to _____
- How does your child act when ill? _____
- What are your child's interests & favorite activities? _____
- Language spoken at home: _____
- Any additional information we should know? _____

Personal Safety Discussions: Our staff will engage children in discussions to help them understand how they can set their own personal safety and touching limits. These discussions will emphasize respect, set the ground rules for appropriate behavior, and encourage children to tell if someone touches them in a way that makes them feel uncomfortable. Blaine Memorial UMC respects the diversity and rights of the individuals it serves.

AUTHORIZATIONS

Participation : I give permission for my child to participate in all activities, including field trips, climbing wall, overnights, and to be transported as authorized by Blaine Memorial UMC. I give permission for Blaine Memorial UMC to use any pictures of my child for future promotional purposes.

Medical Treatment : I hereby give permission for my child to be given cardiopulmonary resuscitation (CPR) and first aid treatment by a qualified staff member of Blaine Memorial UMC. I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment. In the event I cannot be contacted, I further consent to the disclosure of health information and to the medical, surgical and hospital care treatment and procedures (including, but

not limited to, administration of necessary anesthetics, tests, x-ray examinations, transfusions, injections, drugs) to be performed for my child by a licensed physician or hospital selected by the Blaine Memorial UMC director when deemed immediately necessary or advisable by the physician to safeguard my child's health.

I have read and understand the above and have completed this form to the best of my ability.

Signature of parent or legal guardian: _____ **Date:** _____