



Office Use Only
Registration Fee Paid: _____
Rate: Monthly or Drop In
Full Day or Half Day
Siblings? Yes or No
Name(s) of sibling(s):

Registration Form

Full Name of Child _____
First Middle Last

Name Child Goes By _____ Sex _____ Date of Birth ____ - ____ - ____

Mother's Name _____ -- _____ Father's Name _____

Does child live with both parents? Yes _____ No _____ If not, with whom? _____

Street Address or PO Box _____

City/State _____ Zip Code _____

Email Address _____

Home Phone _____ Mother's Cell _____ Father's Cell _____

Church Member? Yes _____ No _____ If yes, where _____

Interested in Church Membership at First Evangelical Lutheran? Yes _____ No _____

Persons to whom child may be released and relationship to child:

Name of person authorized to act for parent in case of emergency:

Name: _____ Phone: _____

Child's Physician _____ Phone: _____

Does your child have allergies? Yes _____ No _____ If yes, what? _____

Please give any other information the teacher should know about your child's physical condition, habits, likes and dislikes, curriculum support needs, etc.

Signature _____ Date _____