

Enrollment Form FUMC Day School

800 West 5th Street
Fort Worth, TX 76102
817-870-9174

Updated _____	Initials _____
Updated _____	Initials _____
Updated _____	Initials _____

Family Information

Last Name	First Name	MI
<input type="text"/>	<input type="text"/>	<input type="text"/>
Relationship to Child		
<input type="text"/>		
Street Address		
<input type="text"/>		
Apartment/Unit		
<input type="text"/>		
City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>
Home Phone	Work Phone	EXT
<input type="text"/>	<input type="text"/>	<input type="text"/>
Cell Phone	Email Address	
<input type="text"/>	<input type="text"/>	

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Relationship to Child		
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Home Phone	Work Phone	EXT
<input type="text"/>	<input type="text"/>	<input type="text"/>
Cell Phone	Email Address	
<input type="text"/>	<input type="text"/>	

Child Information

Last Name	First Name	MI
<input type="text"/>	<input type="text"/>	<input type="text"/>
Sex	Child Street Address	Date of Birth
<input type="text"/>	<input type="text"/>	<input type="text"/>
Emergency Contact	Emergency Phone	
<input type="text"/>	<input type="text"/>	
Street Address		
<input type="text"/>		
Doctor	Doctor Phone	
<input type="text"/>	<input type="text"/>	
Doctor Street Address		
<input type="text"/>		
Insurance Provider	Policy Number	
<input type="text"/>	<input type="text"/>	
Name of Insured		
<input type="text"/>		

Last Name	First Name	MI
<input type="text"/>	<input type="text"/>	<input type="text"/>
Sex	Child Street Address	Date of Birth
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Emergency Contact	Emergency Phone	
<input type="text"/>	<input type="text"/>	
Street Address		
<input type="text"/>		
Doctor	Doctor Phone	
<input type="text"/>	<input type="text"/>	
Doctor Street Address		
<input type="text"/>		
Insurance Provider	Policy Number	
<input type="text"/>	<input type="text"/>	
Name of Insured		
<input type="text"/>		

Emergency Care Authorization

I certify that I am a parent of legal guardian of the child or children named above and give consent for emergency medical care, surgical treatment and/or transportation to a care facility should by Child's condition require it in my absence. I understand that, time and conditions permitting, reasonable attempts will first be made to contact me and any designated representatives in such a case. I hereby assume all financial responsibility for such actions taken on the behalf of my child.

Parent/Legal Guardian's Signature

Date