



OFFICE USE ONLY

Enroll Date: _____
Start Date: _____
Ck #: _____
Amount: _____

Revision 03/2010

Child's Name _____
Last First MI Nickname

Male Female Date of Birth: ____/____/____

Home Address _____

City _____ Zip _____ Family Home #: _____

Family Email Address: _____

School Attending in Fall:

School Name	Grade Entering

PHOTOGRAPHING AGREEMENT

I DO AGREE _____ DO NOT AGREE _____ to give my permission to Sylvan Way Christian Schools for my child to be photographed in any program. Some photos may be saved for electronic media. I understand photos may be taken by: children, staff, professional photographers, news media or other parent. Pictures may appear on bulletin boards, newsletters, yearbook or children's files for legal documentation. I understand I will be notified if photos are to be used for publicity purposes and I have the right to refuse publication.

Parent Signature _____ Date _____

PRIMARY PARENT/GUARDIAN INFORMATION:

(1) Parent Name: _____ Father Mother Other _____

Cell #: _____

Work #: _____

(2) Parent Name _____ Father Mother Other _____

Cell #: _____

Work #: _____

MEDICAL INFORMATION: *(Washington State Requirement)*

Child's Primary Care Physician: _____
(Must be the doctor's name, not the clinic / facility)

Physician's Office Address: _____

Physician's Office Number: _____

Child's Primary Dentist: _____
(Must be the dentist's name, not the clinic / facility)

Dentist's Office Address: _____

Dentist's Office Number: _____

PERMISSION FOR EMERGENCY CARE

I hereby give my permission for my child to be given emergency medical treatment by a qualified staff member at Sylvan Way Christian Schools. I further give permission for my child to be transported by ambulance or car to an emergency center for treatment. In the event that I cannot be contacted, I further consent to medical treatment and procedures, and surgical and hospital care to be performed for my child by a licensed physician when deemed necessary or advisable by that physician for the safeguard of my child's health.

Parent Signature: _____ Date: _____

EMERGENCY CONTACT INFORMATION Please list the names of up to four individuals whom have the authorization to be contacted if you cannot be reached and / or have authorization to pick up your child in the event that you cannot.

Name	Relationship to Child	Daytime Phone #	Cellular Phone #	Please check applicable boxes.
				<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Authorized Pick-Up
				<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Authorized Pick-Up
				<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Authorized Pick-Up
				<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Authorized Pick-Up

CHILD'S MEDICAL INFORMATION

Does your child know how to swim in water over their head? _____ Yes _____ No

(Please note that all children are under adequate supervision by an adult at all times.)

List any life threatening conditions:

Condition	Plan of Care

List any chronic health conditions that would restrict activities:

Condition	Plan of Care

List all allergies:

Allergies	Expected Symptoms	Method of Treatment

List all current medications: _____

