Shining Stars Preschool Registration Form

Registration Form	Date Student Starts:	Date Student Leaves:
Students name: Last First Middle		Birth date:
Street Address	City	Zip code
Student's Parent/Guardians Name	Home/cell phone #	Work phone #
Street Address	City	Zip code
Student's Parent/Guardians Name	Home/cell phone #	Work phone #
Street Address	City	Zip code

Other than you , who else has permission to pick up your child

Name	Address	Telephone Number
Name: Relationship:		Home: Cell: Alternative:
Name: Relationship:		Home: Cell: Alternative:
Name: Relationship:		Home: Cell: Alternative:
Name: Relationship:		Home: Cell: Alternative:

In Case of an Emergency, I give permission for any of the following individuals to be contacted and my child may be released to any of them.

Parent/Guardian signature:_____

Name	Address	Telephone Number
Name: Relationship:		Home: Cell: Alternative:
Name: Relationship:		Home: Cell: Alternative:
Name: Relationship:		Home: Cell: Alternative:

Who does not have permission to pick up your child? If applicable (A copy of supporting court documents must be on file)	
Name	Reason

Child's Health information		
Date of child's last physical exam:	Child's health care provider:	Telephone Number
Street Address	City	Zip code

Special Health problems? Yes or no? If yes, specify.	Allergies, including drug reactions Yes or no? If yes, specify.
Regular Medication: Yes or no? If yes, specify.	Other important information Yes or no? If yes, specify.

Child's dentist's name		Telephone number
Street Address	City	Zip code

Child's medical insurance coverage	
Insurance Company Name	Member/policy number
Policy holder name	Employer name
Insurance company name	Member/policy number
Policy holder name	Employer name

Consent to medical care and treatment of minor children	
I give permission that my child, _____, may be given first aid/emergency treatment by the licensee and/or qualified staff at: Name of Licensee: Shannon L McComb Address of Licensee: 16617 N Cincinnati Ct. Spokane, WA 99208	
Parent/Guardian signature Date	Parent/Guardian signature Date

When I cannot be contacted, I authorize and consent to medical, surgical, and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health. I waive my right of informed consent to such treatment. I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment. I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.