

Parent/Guardian: _____ DOB: _____ Mobile Phone #: _____
Last Name First Name MM/DD/YYYY (At which we can reach you during programs.)

Email: _____ Mobile Carrier: _____

Address: _____
Street City, State & Zip Code Mailing Address (if different):

Parent/Guardian: _____ DOB: _____ Mobile Phone #: _____
Last Name First Name MM/DD/YYYY (At which we can reach you during programs.)

Email: _____ Mobile Carrier: _____

Your relation to the child(ren): _____ Who is **UNAUTHORIZED** to pick up your child(ren)? _____

CHILD INFORMATION		
① Gender: <input type="checkbox"/> M <input type="checkbox"/> F Grade: _____ Name: _____ DOB: _____ <input type="checkbox"/> Medical Condition Requiring Emergency Intervention / Special Needs / Emotional Concerns* Describe: _____	② Gender: <input type="checkbox"/> M <input type="checkbox"/> F Grade: _____ Name: _____ DOB: _____ <input type="checkbox"/> Medical Condition Requiring Emergency Intervention / Special Needs / Emotional Concerns* Describe: _____	③ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Grade: _____ Name: _____ DOB: _____ <input type="checkbox"/> Medical Condition Requiring Emergency Intervention / Special Needs / Emotional Concerns* Describe: _____

*If you checked the box above, you will be required to have a mobile phone on which we can reach you during the Children's Program.

** **Note:** Photography and/or video recordings, which could include your child(ren), may occur during the Children's Program.

CHILD INFORMATION		
④ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Grade: _____ Name: _____ DOB: _____ <input type="checkbox"/> Medical Condition Requiring Emergency Intervention / Special Needs / Emotional Concerns* Describe: _____	⑤ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Grade: _____ Name: _____ DOB: _____ <input type="checkbox"/> Medical Condition Requiring Emergency Intervention / Special Needs / Emotional Concerns* Describe: _____	⑥ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Grade: _____ Name: _____ DOB: _____ <input type="checkbox"/> Medical Condition Requiring Emergency Intervention / Special Needs / Emotional Concerns* Describe: _____

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