



**CHRIST THE KING  
LEARNING AND GROWTH CENTER**  
Enrollment Form

Child's Name: \_\_\_\_\_ Gender \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Start Date: \_\_\_\_\_ *parent email:* \_\_\_\_\_

	Guardian 1	Guardian 2
Name		
Home Address		
Employer phone #		
Home phone #		
Work phone #		
Cell phone #		

Person/s with whom the child lives: \_\_\_\_\_  
 Child's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Preferred Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

Individuals to contact in the case of an emergency:  
 \_\_\_\_\_ Phone#: \_\_\_\_\_  
 \_\_\_\_\_ Phone#: \_\_\_\_\_  
 \_\_\_\_\_ Phone#: \_\_\_\_\_  
 \_\_\_\_\_ Phone#: \_\_\_\_\_

Does your child have any food allergies? No Yes \_\_\_\_\_  
 Does your child have any dietary restrictions? No Yes \_\_\_\_\_  
 Does your child have any special needs? No Yes \_\_\_\_\_  
 Does your child receive any special services? No Yes \_\_\_\_\_  
 Will your child receive services at the center? No Yes \_\_\_\_\_  
 Name of service provider and frequency \_\_\_\_\_

My child has permission to be released to the following individuals or transportation services in addition to the emergency contact persons listed above. (Please notify all individuals that they may be asked to show proof of identity)

Name	Relationship

I authorize this program and its representatives to get emergency medical treatment for my child if necessary.  
 Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 April 1, 2020