

REGISTRATION  
FORM

Ck#: \_\_\_\_\_

Amount: \_\_\_\_\_

**CHILD**

Name		Registration Date	Sex (Circle One) <b>M      F</b>
Street Address		First Date of Attendance	<b>Program Selection:</b> 3 yr – MWF    TTH  MTWTh  4 yr – M   T   W   Th
City/State/Zip Code		Nickname	
Home Phone		Date of Birth	
Physician	Physician's Phone		VPK Certificate Number

Email address: \_\_\_\_\_ Child Lives With: \_\_\_\_\_

Name ( <b>Mother</b> )	Name( <b>Father</b> )
Street Address, if different from child	Street Address, if different from child
City/State/Zip Code	City/State/Zip Code
Home Phone	Home Phone
Place of Employment	Place of Employment
Occupation	Occupation
Business Phone	Business Phone
Cell Phone	Cell Phone

**Please Initial Custody: (Circle Days for Joint Custody)**  
Both Parents \_\_\_\_\_ Mother: MTWTHF \_\_\_\_\_ Father: MTWTHF \_\_\_\_\_ Other \_\_\_\_\_

**Specific Custody Arrangements:**

**EMERGENCY CONTACTS**

Name	Phone	Address	Relationship	***

\*\*\*A check mark in this column denotes that the person indicated is authorized to take my child from the facility in cases of emergency or when no parent or legal guardian can be located or reached.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

The following information is requested in order to help us get to know your child better.

Child's Name \_\_\_\_\_

Primary Language Spoken in the Home \_\_\_\_\_ Other Language Spoken in the Home \_\_\_\_\_

Sibling Name(s)	Age

Please indicate if your child has any of the following:

- |  |   |
|--|---|
| <input type="checkbox"/> Disability              | <input type="checkbox"/> Speech Impairments             |
| <input type="checkbox"/> Health Concerns         | <input type="checkbox"/> Vision Impairments             |
| <input type="checkbox"/> Coordination Concerns   | <input type="checkbox"/> Hearing Impairments            |
| <input type="checkbox"/> Eating / Food Concerns  | <input type="checkbox"/> Shyness                        |
| <input type="checkbox"/> Food Allergies          | <input type="checkbox"/> Outgoing Personality           |
| <input type="checkbox"/> Medication Allergies    | <input type="checkbox"/> Medical Concerns – List: _____ |
| <input type="checkbox"/> Allergies – List: _____ |   |

We wish to respect the customs and practices of every culture. Please inform us if your family has any special practices that you wish to share with the Heathrow Christian Academy.

\_\_\_\_\_  
\_\_\_\_\_  
Additional Comments and Information  
\_\_\_\_\_  
\_\_\_\_\_

I, (Printed name of parent or legal guardian) \_\_\_\_\_, understand that Florida Law requires that I provide to Heathrow Christian Academy a current physical examination (Form 3040) and an immunization record (Form 680 or 681) within 30 days of enrollment.

I, (Printed name of parent or legal guardian) \_\_\_\_\_, Have received a copy of the Child Care Facility brochure, *Know Your Child's Day Care Center*.

I, (printed name of parent or legal guardian) \_\_\_\_\_, Have been notified in writing of the disciplinary practices used by the childcare facility (this is included in the parent handbook).

I, (printed name of parent or legal guardian) \_\_\_\_\_, certify that I have legal custody of (Printed name of the child) \_\_\_\_\_.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

# Heathrow Christian Academy at Markham Woods Presbyterian Church Parental Consent Form

## Parental Consent for Emergency Treatment

Student's Full Name \_\_\_\_\_ Age \_\_\_\_\_

In the event of serious accident or illness, I request the school contact me. If I cannot be reached, the school may make whatever arrangements are necessary to provide emergency care and treatment for my child. This may include conveyance to and treatment at a hospital or other medical facility. I will assume responsibility of payment for the services rendered.

In the case of an accident or illness where immediate treatment of my child is not indicated, but where he/she is unable to remain in school I request that one of the persons listed below will be contacted to care for my child.

Heathrow Christian Academy. does not provide benefits for injuries.

Date \_\_\_\_\_ Parent or Legal Guardian Signature \_\_\_\_\_

Home Phone # \_\_\_\_\_

Cell Phone # \_\_\_\_\_

Work Phone # \_\_\_\_\_

Pager # \_\_\_\_\_

### Emergency Contacts

Name	Relationship	Phone #
_____	_____	_____
_____	_____	_____

Please complete the following:

Check One	Race		Check One	Primary Language Spoken
<input type="checkbox"/>	White/Non-Hispanic	<input type="checkbox"/>	<input type="checkbox"/>	English
<input type="checkbox"/>	Black/Non-Hispanic	<input type="checkbox"/>	<input type="checkbox"/>	Spanish
<input type="checkbox"/>	Hispanic	<input type="checkbox"/>	<input type="checkbox"/>	Creole
<input type="checkbox"/>	Asian/Pacific Islander	<input type="checkbox"/>	<input type="checkbox"/>	Haitian-Creole
<input type="checkbox"/>	American Indian /Alaskan Native	<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	Multiracial	<input type="checkbox"/>		
<input type="checkbox"/>	Unknown	<input type="checkbox"/>		

How did you hear about our school? Email \_\_\_\_\_ Website \_\_\_\_\_ Publication \_\_\_\_\_ Friend \_\_\_\_\_  
Other: \_\_\_\_\_

## Parental Consent to Publish Address and Home Telephone Number

\_\_\_\_\_ I would like my email address to be included in the class list shared only with other parents within Heathrow Christian Academy

\_\_\_\_\_ **I DO NOT** wish to include our email address to be included in the class list shared only with other parents within Heathrow Christian Academy.

## Parental Acknowledgement per DCF:

\_\_\_\_\_ I understand school personnel to have access to my child's records.

## Parental Consent for Photographs and Videos of child

\_\_\_\_\_ I give permission for my child \_\_\_\_\_ to be photographed or video taped at Heathrow Christian Academy. by teachers and other parents and for these pictures to be viewed in the classroom and private use only.

\_\_\_\_\_ **I DO NOT** give permission for my child to be photographed or videotaped.

## Parental Consent for Publication of Photos on Church Website

\_\_\_\_\_ I give permission for my child \_\_\_\_\_'s photo to be used on the MWPC website. Photos will not identify the students by name.

\_\_\_\_\_ **I DO NOT** give permission for my child's photo to be used on the MWPC website.

## Parental Consent for Food Related Activities

\_\_\_\_\_ I give permission for my child \_\_\_\_\_ to participate in food-related activities, such as special occasions and learning activities, which include food consumption.

\_\_\_\_\_ **I DO NOT** give permission for my child \_\_\_\_\_ to participate in food-related activities, such as special occasions and learning activities, which include food consumption.

**Permission for Observation/Screening** to be performed by a trained employee of the Early Learning Coalition of Seminole County or Seminole County Public School System.

I **do** \_\_\_\_\_ **do not** \_\_\_\_\_ grant permission to have my child observed and/or screened for potential delays, challenging behaviors or other concerns.

**Parent/Guardian Signature:** \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

If child was born prematurely, how early was the birth?

Is your child currently receiving therapy of any kind? Yes \_\_\_\_\_ No \_\_\_\_\_

(If yes, please list type of therapy \_\_\_\_\_)

Other (i.e. relevant medical condition, sibling with a disability etc) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_