



The Children's School 2020-21 Registration Application
1 West Macon
Savannah, Georgia 31401
232.1225

Entry level of child (determined by child's age as of September 2020)

Infants (3-11 months)	2 day program	_____	
Toddlers (12-24 months)	2-day program	_____	
Two year olds	2-day program	_____	3-day program_____ 5-day program_____
Three year olds	3-day program	_____	5-day program_____
Pre K	3-day program	_____	5-day program_____

Student information:

Student's Full Name _____

Name Called: _____ Sex _____ Birth date ___/___/___

Home Address: _____
(Street) (City) (Zip Code)

Home Phone Number _____

Father's/Guardian's Name: _____

Place of Employment: _____

Occupation: _____

Work Phone Number: _____

Cell Phone Number: _____

Email Address: _____

Mother's/Guardian's Name: _____

Place of Employment: _____

Occupation: _____

Work Phone Number: _____

Cell Phone Number: _____

Email Address: _____

Sibling(s):

Name: _____ Sex: _____ Birth date: __/__/__

Name: _____ Sex: _____ Birth date: __/__/__

Additional Information:

Church Affiliation: _____

Please list any special needs, interests, or any other information about your child that we should know:

Should your child's physical activity be restricted in anyway? If so, please explain.

Are you interested in volunteering in the classroom? If so, in what capacity?

Emergency Medical Release Form 2020-21

Student's Name: _____ Date of Birth: _____

Name of Physician: _____ Physician's Phone Number: _____

1. Please list any disease, allergies, etc. that your child has

2. Does your child have any unusual developmental and/or medical concerns? If so, please describe.

3. In the event of an emergency, every effort possible will be made to reach a parent/guardian. Should we be unable to reach a parent/guardian, please list the names and phone numbers of two people whom we may contact in the event of an emergency.

a.

(Name)	(Relationship)	(Phone Number)
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b.

(Name)	(Relationship)	(Phone Number)
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I understand that I am not to bring my child to The Children's School if he/she has a fever, constantly runny nose, rash, or any other potentially contagious illness. If the staff feels that my child is sick, I will be called to come and get my child.

In the event that a parent or guardian cannot be reached in an emergency, I hereby give my permission for the staff to secure any necessary medical attention for my child.

The hospital preferred by my insurance company is _____.

I certify that my child's immunizations are current and I will keep them up-to-date throughout the school year. (Please attach a copy of your child's current immunization record.)

Signature of Parent/Guardian

Date