



## ENROLLMENT FORM

School Term: 2021-2022

Class Placement:

\_\_\_\_\_

### Student's Information

Student's Name: \_\_\_\_\_  
Last First Middle

Preferred Name: \_\_\_\_\_ Gender: \_\_\_\_\_ SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Church Affiliation: \_\_\_\_\_

### Primary Family Information

Address Line 1: \_\_\_\_\_  
Street Apt. #

Address Line 2: \_\_\_\_\_  
City State Zip Code County

Home Phone (if applicable): \_\_\_\_\_

### Parent's Information

Parent's Name: \_\_\_\_\_  
Last First Middle

Preferred Name: \_\_\_\_\_ Title: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Emergency Contact  Allowed to pick up child

Company Name: \_\_\_\_\_ Job Title: \_\_\_\_\_

Business Phone: \_\_\_\_\_

### Parent's Information

Parent's Name: \_\_\_\_\_  
Last First Middle

Preferred Name: \_\_\_\_\_ Title: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Emergency Contact  Allowed to pick up child

Company Name: \_\_\_\_\_ Job Title: \_\_\_\_\_

Business Phone: \_\_\_\_\_

**Pickup Information** (People authorized to pickup children from school other than parents)

Name: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Name: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Name: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

**Emergency Contacts** (other than parents)

**1st Choice** Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Home #: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell #: \_\_\_\_\_

**2nd Choice** Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell#: \_\_\_\_\_

**3rd Choice** Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Home #: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell #: \_\_\_\_\_

**Medical Contacts**

Physician: \_\_\_\_\_

Phone #: \_\_\_\_\_

Dentist: \_\_\_\_\_

Phone #: \_\_\_\_\_

Hospital of Choice: \_\_\_\_\_

Insurance: \_\_\_\_\_

Policy #: \_\_\_\_\_

I hereby authorize First Presbyterian Church to take my child to the above named physician or facility for medical treatment in the event of an emergency in which neither parent can be reached.

I hereby authorize any licensed physician or medical treatment facility to treat my child in case of an emergency in which the above physician can not respond.

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

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

For Office Use Only

Reg. Fee Date: \_\_\_\_\_

Entrance Date \_\_\_\_\_

Check #: \_\_\_\_\_ Amt.: \_\_\_\_\_

Withdrawal Date \_\_\_\_\_