

TCA Early Morning Care and Extended School Day Enrollment Form

Name _____ Grade _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

MOTHER _____ Drivers License Number: _____

Cell Phone _____ Home Phone _____ Work Phone _____

FATHER _____ Drivers License Number: _____

Cell Phone _____ Home Phone _____ Work Phone _____

Emergency Contact _____ Phone _____
(Please list someone other than a parent)

Does your child have any allergies? Yes _____ No _____

Explain: _____

Usual Treatment: _____

*** Parents who are divorced must provide a legal copy of document
Preventing the other parent from taking the child from the premises. ***

The following persons may pick up my child.

Name _____ Relationship to Child _____

Name _____ Relationship to Child _____

Name _____ Relationship to Child _____

Name _____ Relationship to Child _____

INSURANCE INFORMATION

Ins. Co. _____ Insured _____ Policy # _____ Group# _____

Name and address of parent financially responsible for medical treatment:

Health Care Professionals Preferred:

Name

Phone Number

Child's Doctor _____

Hospital _____

Child's Dentist _____

Should my child become ill or suffer an accident of any kind while he/she is in the care of the EMC/ESD staff, the staff shall undertake to contact me immediately. In the event the EMC/ESD staff is unable to reach me immediately, the EMC/ESD staff shall be authorized to secure and consent to such medical attention, treatment and services for my child as may be deemed necessary.

Any qualified person providing such required medical attention, treatment or services may accept such consent as if given by me in person. I agree to assume all financial responsibility for full payment in full of any medical costs incurred.

Date _____ **Signature of Father** _____

Date _____ **Signature of Mother** _____

TCA Summer Day Camp Application Year: _____

Name _____ Last Grade Attended _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

MOTHER _____ Drivers License Number: _____

Cell Phone _____ Home Phone _____ Work Phone _____

FATHER _____ Drivers License Number: _____

Cell Phone _____ Home Phone _____ Work Phone _____

Emergency Contact _____ Phone _____

(Please list someone other than a parent)

Does your child have any allergies? Yes _____ No _____

Explain: _____

Usual Treatment: _____

*** Parents who are divorced must provide a legal copy of document
Preventing the other parent from taking the child from the premises. ***

The following persons may pick up my child.

Name _____ Relationship to Child _____

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INSURANCE INFORMATION

Ins. Co. _____ Insured _____ Policy # _____ Group# _____

Name and address of parent financially responsible for medical treatment:

Health Care Professionals Preferred:

Name

Phone Number

Child's Doctor _____

Hospital _____

Child's Dentist _____

Should my child become ill or suffer an accident of any kind while he/she is in the care of the SDC staff, the staff shall undertake to contact me immediately. In the event the SDC staff is unable to reach me immediately, the SDC staff shall be authorized to secure and consent to such medical attention, treatment and services for my child as may be deemed necessary.

Any qualified person providing such required medical attention, treatment or services may accept such consent as if given by me in person. I agree to assume all financial responsibility for full payment in full of any medical costs incurred.

Date _____ **Signature of Father** _____

Date _____ **Signature of Mother** _____