2023 - 24 PRESCHOOL ENROLLMENT CARD

Entering Room: _____

Student ID: _____

STUDENT _____

Last Name: First Name: Middle Name:

Birthdate: _____ Age (In the Fall): _____ Gender (M/F) _____

Address: _____

City: _____ Zip Code: _____ Home Phone: _____

FATHER/GUARDIAN'S NAME: _____

(Home Address if Different from above) Last: First:

Same ☐ Address: _____ City: _____ Zip: _____

Home Phone: _____ E-mail Address: _____

Employer/Position: _____ Work #: _____ Ext: _____

City: _____ State: _____ Zip: _____ Cell # _____

MOTHER/GUARDIAN'S NAME: _____

(Home Address if Different from above) Last: First:

Same ☐ Address: _____ City: _____ Zip: _____

Home Phone: _____ E-mail Address: _____

Employer/Position: _____ Work #: _____ Ext: _____

City: _____ State: _____ Zip: _____ Cell # _____

CHILD LIVES WITH _____ RELATIONSHIP _____

OTHER CHILDREN ATTENDING CLS (GRADES) _____

CHURCH AFFILIATION ☐ Member of Christ Lutheran Church ☐ No Church Membership

☐ Member of _____ Church

RACE/ETHNICITY (Please mark the group your child most closely identifies with)

☐ African American Black ☐ American Indian/Alaska Native ☐ Arab/Middle Eastern

☐ Asian/Pacific Islander ☐ Hispanic/Latino ☐ White (not of Hispanic origin)

☐ Other (include multicultural families) Specify: _____

ATTENDANCE SELECTION

START DATE

Please circle # of days and whether your child will attend FULL or HALF days:

 # OF DAYS: ~~2~~ ~~3~~ 5 HALF DAYS or FULL DAYS

PLEASE COMPLETE THE REVERSE SIDE ----------

2023 - 24 PRESCHOOL ENROLLMENT CARD

Entering Room: _____

Student ID: _____

STUDENT _____

Last Name: First Name: Middle Name:

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

Doctor's Name/Phone: _____

Allergies/Special Medical Information: _____

_____

(I) (We)the undersigned, parent(s)/legal guardians of _____
a minor, do hereby authorize (insert names of three persons other than parents or legal guardians over 21 years of age)

Name	Relationship	Phone (Home/Cell)
Address	Phone (Work/Cell)	Phone (Cell)
Name	Relationship	Phone (Home/Cell)
Address	Phone (Work/Cell)	Phone (Cell)
Name	Relationship	Phone (Home/Cell)
Address	Phone (Work/Cell)	Phone (Cell)

as agents for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or at a hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exerise of his best judgement may deem advisable; and neither said agent or any organization involved assumes any financial responsibility for exercising this action. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

Name of Mother or Legal Guardian: _____

Signature of Mother or Legal Guardian: _____ Date: _____

Name of Father or Legal Guardian: _____

Signature of Parent(s) or Legal Guardian: _____ Date: _____

IMPORTANT - Please Complete Reverse Side