

# St. Mark's Children's Hour Registration

## 2018-2019



Date \_\_\_\_\_

Child's name (first and last): \_\_\_\_\_ Nickname: \_\_\_\_\_ Sex: F M (circle one)

Primary Phone ( ) \_\_\_\_\_ Home/Cell (circle one) Age: \_\_\_\_\_ birthday \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_

Alternative Phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_

Alternative Phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

**Parents are always contacted first. Please list local contact in the event that a parent cannot be reached.**

**EMERGENCY CONTACT:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** ( ) \_\_\_\_\_

Other than the mother or father, who may pick-up your child? \_\_\_\_\_

Siblings (and their ages): \_\_\_\_\_

Church Affiliation: \_\_\_\_\_ St. Mark's \_\_\_\_\_ Other, please specify \_\_\_\_\_

Does your child have any fears/anxieties? If so, please explain: \_\_\_\_\_

Do you have any behavioral or development concerns about your child? If so, please explain: \_\_\_\_\_

Child's previous group experience: \_\_\_\_\_

Child's interests: \_\_\_\_\_

*Please return this form along with the \$35 yearly fee to St. Mark's Lutheran Church*

**Darcie Pomykata, Director**  
**St. Mark's Lutheran Church**  
**201 West Jefferson Street**  
**Butler, PA 16001**

[youth@stmarksbutler.org](mailto:youth@stmarksbutler.org)

724-996-9245 (cell)

(over)

Official use only

Today's date \_\_\_\_\_

Paid Registration \_\_\_\_\_

Initials \_\_\_\_\_

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

Physical History:

Family Physician: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

Chronic illnesses: \_\_\_\_\_

Allergies to Foods: \_\_\_\_\_

Regular medications: \_\_\_\_\_ Does your child have an EpiPen? \_\_\_\_\_

Has your child previously had chicken pox? \_\_\_\_\_ Has had Vaccines? \_\_\_\_\_

Toileting practices (any known difficulty) \_\_\_\_\_

Vision/hearing/speech (any known difficulty) \_\_\_\_\_

First Aid/Medical care: and/or treatment consent:

**I authorize staff in the child care program who are trained in the basics of first aid to give my child first aid when appropriate.**

**I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to \_\_\_\_\_, and to secure necessary medical treatment for my child.**

I authorize all medical, diagnostic, surgical, and hospital procedures as may be performed or prescribed by a treating physician if I cannot be reached in an emergency.

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

**I give my permission to use finger paints and other non-toxic art/craft materials. Yes\_\_\_\_\_ No\_\_\_\_\_**

**I give my permission to have pictures taken of my child and have them placed in the Church Newsletter and on the Church Website. Yes\_\_\_\_\_ No\_\_\_\_\_**

**I give permission to share my child's name listed with their picture for the publications listed above.**

Yes\_\_\_\_\_ No\_\_\_\_\_

Parent / Guardian's

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