St. Mark's Children's Hour Registration

2023-2024

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 Affliliation:_____ 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

Darcie.Pomykata@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 publications and on the Church Websites. 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:_____