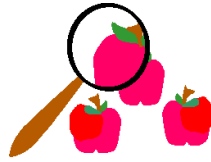


**Allergies:**  
**(Indicate if none)**

EPIPEN? Yes No  
(circle one)

Protocol must be provided  
and signed by doctor and  
parent if "yes"



**Medical Alerts:**  
**(indicate if none)**

Protocol must be provided  
and signed by doctor and  
parent if needed

## Classroom of Discovery Registration Form

Please fill in each blank. If something is not applicable, please indicate with "n/a" or "none."

Child's Full Name \_\_\_\_\_

Child's Nickname \_\_\_\_\_ Child's Birthdate \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Mom's Full Name: \_\_\_\_\_

Address & Phone if Different from Child's: \_\_\_\_\_

Dad's Full Name: \_\_\_\_\_

Address & Phone if Different from Child's: \_\_\_\_\_

Preferred Email Address: \_\_\_\_\_

Mom's Work Phone: \_\_\_\_\_ Mom's Cell: \_\_\_\_\_

Mom's Place of Work & Address: \_\_\_\_\_

Dad's Work Phone: \_\_\_\_\_ Dad's Cell \_\_\_\_\_

Dad's Place of Work & Address: \_\_\_\_\_

**If Mom or Dad cannot be Reached, Please Call to Pick up my Child (Please Provide Complete Addresses):**

(1) \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

(2) \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

Other Person(s) Authorized To Pick Up My Child:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

## AGREEMENTS

The Classroom of Discovery agrees to notify the parent(s) whenever his/her child becomes ill and the parent(s) will arrange to have the child picked up as soon as possible if requested by the school.

The parent(s) agree to inform the Classroom of Discovery within 24 hours or the next business day after his/her child or any member of the immediate household has developed a reportable communicable disease, as defined by the State Board of Health, except for life threatening diseases which must be reported immediately.

The parent(s) authorize the Classroom of Discovery to obtain immediate medical care if any emergency occurs when the parent(s) cannot be located immediately. \*\*

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Director's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*If there is an objection to seeking emergency medical care, the parent(s) must provide a written statement that states the objection and the reason for the objection.

I give permission for my child to take walking field trips to Briar Patch Park during school hours. I will provide permission on a case-by-case basis for additional field trips throughout the year.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Schools Attended prior to the Classroom of Discovery: \_\_\_\_\_

Allergies or Intolerance to Food or Medication and Action to take in an Emergency: \_\_\_\_\_

Chronic Physical Problems/Pertinent Developmental Information/Special Accommodations Needed: \_\_\_\_\_

|  |  |  |  |
|--|--|--|--|
| <b>CLASSROOM OF DISCOVERY STAFF USE ONLY</b> |  |  |  |
| <b>IDENTITY VERIFICATION</b>                 |  |  |  |

|   |                   |                                  |                                     |
|---|-------------------|----------------------------------|-------------------------------------|
| <b>Place of Birth</b>   | <b>Birth Date</b> | <b>Birth Certificate Number</b>  | <b>Date Issued</b>                  |
| <b>Other Form of Proof</b>  |                   | <b>Date Documentation Viewed</b> | <b>Person Viewing Documentation</b> |
| <b>Date of Notification of Law Enforcement (when proof is not provided)</b> |                   |                                  |                                     |
| <b>Date Started CoD</b>   |                   | <b>Date Left CoD</b>             |                                     |

*The Classroom of Discovery admits children without regard to race, religion, cultural heritage, political beliefs, disability, marital status of family, family life style or national origin.*