KIDS CONNECTION LTD L4370

After School _____ Before & After School_____ Full Days _____

School _____ Teacher's Name _____

Child's **Full** Name _____

Date of Birth _____ Age_____ Grade_____
Month Day Year

Child's Address _____

_____Postal Code_____

Mom's Name_____ Place Of Employment _____

Home#_____ _ Work#_____ Cell#_____

Dad's Name _____Place of Employment _____

Home#_____Work#_____Cell#_____

Mom email _____Dad email_____

Contact Person & Phone_____

Medical/Physical Conditions, allergies:_____

_____

Health # _____

Doctor's Name_____Phone #_____

I give permission for the following people that I have listed to pick up my child from Kids Connection if I am unable to do so:

If subsidized, parent share amount, to be paid to the center on the first of the month $_____

Emergency Medical Consent: I hereby give permission for the Supervisor and staff of Kids Connection to act on my behalf in obtaining and/or authorizing medical treatment, if an emergency arises and I cannot be contacted by telephone. I understand that any treatment would be on the advice of a qualified medical doctor.

Payment due the first week of each month

Dated _____Signature _____