Do you currently have a church home? YES NO

Child's Physician or Clinic's Name (Child's Primary Health Source)

____

Physician or Clinic's Phone Number: ______________________________

Does your child have any special needs? YES NO (If yes, please explain): ____

____

____

Are there any special accommodations that may be required to most effectively meet your child's needs while at this center? NONE YES (If so, please explain): ____

____

____

Is your child currently on medications prescribed for long-term continuous use and/or have a pre-existing illness, allergies, or health concerns? NO YES (If yes, please explain): ____

____

____

Do we have permission to use your child's picture for advertisement, our church website or social media? YES NO

EMERGENCY MEDICAL AUTHROIZATION

Should my child, ____________________________, suffer an injury or illness while in the care of First Baptist Church After School Program and they are unable to contact me/us immediately, the First Baptist Church After School Program shall be authorized to secure such medical attention and care for the child as may be necessary. I/We agree to keep the facility informed of changes in medical conditions, telephone numbers, etc., where I/we may be reached.

First Baptist Church After School agrees to keep me informed of any incidents requiring professional medical attention involving my child.

____ ____________________

Signature of Parent/Guardian **Date**