



Camp Jade CHILD ENROLLMENT

The Special Learning Center
1115 Fairgrounds Rd.
Jefferson City, MO 65109
(573) 634-3070

CHILD'S NAME:	SEX:	BIRTHDATE:
ADDRESS: Street: _____ City/State/Zip: _____	HOME PHONE NUMBER ()	
IDENTIFYING INFORMATION		
A) MOTHER'S OR GUARDIAN'S NAME:	HOME PHONE NUMBER: ()	
E-MAIL ADDRESS:	MOM'S CELLPHONE NUMBER: ()	
HOME ADDRESS OR <input type="checkbox"/> SAME AS CHILD'S ABOVE) Street: _____ City/State/Zip: _____	BUSINESS TELEPHONE NUMBER: () _____ BUSINESS ADDRESS: _____ _____	
NAME OF EMPLOYER (OR SCHOOL ATTENDING):	HOURS OF EMPLOYMENT FROM _____ TO _____	
B) FATHER'S OR GUARDIAN'S NAME:	HOME PHONE NUMBER: ()	
E-MAIL ADDRESS:	DAD'S CELLPHONE NUMBER: ()	
HOME ADDRESS OR <input type="checkbox"/> SAME AS CHILD'S ABOVE Street: _____ City/State/Zip: _____	BUSINESS TELEPHONE NUMBER: () _____ BUSINESS ADDRESS: _____ _____	
NAME OF EMPLOYER (OR SCHOOL ATTENDING):	HOURS OF EMPLOYMENT FROM _____ TO _____	
EMERGENCY CONTACT(S) (OTHER THAN PARENT(S) OR DOCTOR) – (AT LEAST ONE EMERGENCY CONTACT IS REQUIRED)		
NAME OF EMERGENCY CONTACT:	TELEPHONE NUMBER: ()	
ADDRESS: STREET : _____ CITY, STATE, ZIP CODE: _____	RELATIONSHIP	
Optional	NAME OF EMERGENCY CONTACT:	TELEPHONE NUMBER: ()
	ADDRESS: STREET : _____ CITY, STATE, ZIP CODE: _____	RELATIONSHIP
PERSON(S) AUTHORIZED TO TAKE CHILD FROM THE SPECIAL LEARNING CENTER:		
Name: _____		Name: _____

COMMENTS ON CHILD'S DEVELOPMENT (Note allergies, medications, health concerns, habits, special/language development, etc.)

AUTHORIZATION FOR EMERGENCY MEDICAL CARE:

I understand that I will be notified at once in case of accident or illness to my child and that I will make arrangements for medical care of my child with the physician or hospital of my choice.

If I cannot be reached to make the necessary arrangements or in a critical emergency requiring medical care, I hereby authorize the SPECIAL LEARNING CENTER to contact:

(Please list the name/phone number of doctor, hospital OF YOUR CHOICE or both.)

Name of Doctor/Clinic: _____ **Phone:** _____
Address: _____
City/State/ZIP: _____

Name of Doctor/Clinic: _____ **Phone:** _____
Address: _____
City/State/ZIP: _____

TRIP AND ACTIVITY PERMISSION:

- I do give consent for my child to take part in field trips with the Special Learning Center under proper supervision, and I will be notified when such trips are planned.
- I do not give consent for my child to take part in field trips with the Special Learning Center under proper supervision, and I will be notified when such trips are planned.

PHOTO RELEASE:

- I do hereby give my permission for pictures and/or information concerning me to be used by the Special Learning Center for educational purposes in newspapers, magazines, radio, television, or internet (website).
- I do not give my permission for pictures and/or information concerning me to be used by the Special Learning Center for educational purposes in newspapers, magazines, radio, television, or internet (website).

AGREEMENTS:

- a) The provider and I have agreed on a plan for continuing communication regarding my child's development,
- b) When my child is ill, it is understood and agreed that she/he may not be accepted for care.
- c) This certifies that this information is current and accurate to the best of my understanding.

Parent/Legal Guardian's Signature

Date: _____