

Child History and Release Form
Westminster Kids
Early Learning Program

Child's Name _____ Birthdate _____ Sex _____

Parents' Relationship to Each Other: Married Divorced Separated Single

Child lives with (please check all that apply):

Mother and Father Mother Father Other _____

Mother's Name _____ Phone _____
Home Address _____ Driver's License _____
City _____ State _____ Zip _____
Occupation _____ Employer _____
Work Phone _____ Pager _____ Mobile _____

Father's Name _____ Phone _____
Home Address _____ Driver's License _____
City _____ State _____ Zip _____
Occupation _____ Employer _____
Work Phone _____ Pager _____ Mobile _____

Siblings: _____

Family religious preference _____ Church Membership _____

How did you find our about our program? _____

List at least one local person who will be available to assume responsibility for your child in an emergency if parents cannot be reached.

Name _____ Relationship to child _____
Address _____ Driver's License _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Mobile _____

Release of Child

I authorize that my child, _____, be released by Westminster Kids ELP to the following persons, in addition to those already listed on this form.

Name _____ Relationship to child _____
Address _____ Driver's License _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Mobile _____

Name _____ Relationship to child _____
Address _____ Driver's License _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Mobile _____

Name _____ Relationship to child _____
Address _____ Driver's License _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Mobile _____

Emergency Medical Care

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the Early Learning Program staff to take my child to an Emergency Room, or to the following physician or his/her associates, for medical care.

Dr. _____ Hospital _____
Address _____ Phone _____
City _____ State _____ Zip _____
Special Instructions _____

**I give consent for any and all treatment deemed necessary by the attending physician.
(Attach a photocopy of your insurance card.)**

(Signature of Parent/Guardian)

Allergies: _____

Food Allergies: _____

Bee Stings: Local reaction only; red/swollen at site. Instructions: _____

Severe reaction; difficulty breathing, life threatening, etc.

Instructions: _____

Other medical problems/comments: _____

No medications will be administered at the Early Learning Program.

For Office Use Only

Date of Enrollment _____ Class Assignment _____