

**THE HIDE OUT SMART START PRESCHOOL PROGRAM REGISTRATION
FALL 2010-2011**

Family Information

<u>Child</u>	Name _____	D.O.B. _____
	Address _____	Age ____ Yrs ____ Months
	_____	(As of September 2010)
<u>Mother</u>	Name _____	Employer _____
	Address _____	Address _____
	_____	_____
	Phone _____	Phone _____
	Email _____	Cell# _____
<u>Father</u>	Name _____	Employer _____
	Address _____	Address _____
	_____	_____
	Phone _____	Phone _____
	Email _____	Cell# _____

Educational Information

_____ ~ 3 year old Program ~ Tuesday & Thursday

_____ ~ 3 year old Program ~ Monday through Friday

_____ ~ 4 year old Program ~ Monday, Wednesday, Friday

_____ ~ 4 year old Program ~ Monday through Friday

Emergency / Medical Information

Emergency/Alternate Pick Up: The following listed people **must be local** and cannot be one of the child's parents. The Hide Out has permission to call these people in the event of an emergency or when you cannot be reached. These people may also pick up your child at any time.

	(Name)	(Relationship to Child)	(Phone #'s)
1.	_____	_____	_____
2.	_____	_____	_____

Physician: Name _____ Phone # _____

Insurance: Carrier _____ Policy # _____

Allergies: _____

In the event of a medical emergency, I _____ grant my permission to The Hide Out to administer first-aid, if needed, and to obtain medical treatment for my child _____ . I hereby authorize The Hide Out to contact on my behalf an ambulance and/or E.M.T. service to transport my child to the nearest or most appropriate emergency facility, and to treat accordingly in their professional judgment. I will assume any medical and transportation cost incurred.

Signed _____ **Date** _____