



Preschool Registration Form Chapel - Hill Carrboro YMCA

A \$30 Registration fee is due at time of registration.



RECEIPT #

First Name: _____ Last Name: _____ Sex: ____ DOB: ____/____/____
Must be 3 by June 1

Local Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian: _____ Home #: _____ Work #: _____ Cell # _____

Parent/Guardian: _____ Home #: _____ Work #: _____ Cell # _____

Parent/Guardian email: _____ Parent/Guardian email: _____

Siblings Names and Ages: _____ Languages Spoken _____

Child's Likes _____

Dislikes _____

Emergency Contact: _____ Home Phone: _____ Work Phone: _____

Person (s) to whom your child may be released in your absence:

Name: _____ Home Phone: _____ Work Phone: _____

Name: _____ Home Phone: _____ Work Phone: _____

.....MEDICAL HISTORY: INFORMATION MUST BE COMPLETED.....

Child's Physician: _____ Location: _____ Phone: _____

Name of Hospital you prefer in case of an emergency: _____

Carrier: _____ Policy or Group ID #: _____

Please indicate if your child has had any recent operations or serious injuries. In addition please indicate if there are any other chronic illnesses or allergies that we need to be made aware of. Please list all medications your child is taking.

PARENT/GUARDIAN AUTHORIZATION:

All health history and information provided above is correct so far as I know and I am hereby giving my permission for the person herein described to engage in all prescribed activities.

I also hereby give my permission to the physician selected by the Director to order X-rays, routine tests and any treatment for the health of my child in the event I cannot be reached in an emergency.

I also hereby give my permission to the physician selected by the Director to hospitalize, secure proper treatment for, to order injection and/or anesthesia, and/or surgery for my child as named above on this application.

Parent/Guardian Signature _____ Date _____

FIRST NAME

LAST NAME

FOR OFFICE
USE ONLY