SUMMER

FIRST SCHOOL REGISTRATION 2024
695 Calvin St., Fayetteville, AR 72703

☐Session 1: June 3-June 27 ☐ Session 2: July 8-Aug 1 ☐Both

☐ Monday/Wednesday ☐8:00 a.m. – Noon ☐8:00 a.m. – 2:30 p.m.

☐Tuesday/Thursday ☐8:00 a.m. – Noon ☐8:00 a.m. – 2:30 p.m.

☐Monday-Thursday (if available) ☐8:00 a.m. – Noon ☐8:00 a.m. – 2:30 p.m.

☐ **Parents Day Out** ☐ **Preschool** ☐**Elementary**

Name Child goes by: _____ Current age___ DOB__/__/__

Child's Full Name: _____Gender: M /F

Child's primary residence is with: ☐Mother ☐Father ☐Both ☐Guardian

Parents are: ☐ Married ☐ Divorced ☐ Separated ☐ Single

If divorced, who has custody? ☐Mother ☐Father ☐Both ☐Guardian

If applicable, is the non-custodial parent authorized to pick-up your child? ☐ yes ☐ no

(If no, please provide a copy of court custody papers.)

Mother's name_____ Home: (___) _____

Address_____ City _____Zip _____

Employer/Occupation_____ Work: (___)_____

Work Hours_____ Email_____ Cell: (___)_____

Father's name_____ Home: (___)_____

Address_____ City _____Zip _____

Employer/Occupation_____ Work:(___) _____

Work Hours_____ Email_____ Cell: (___)_____

Emergency Contact Information/Authorized Pick-Up

Please provide the following information on an emergency contact person if the parent or guardian cannot be reached. Please include all others who will be picking up your child. We cannot release a child to anyone without this consent. Any person picking up the child who is unknown to the First School staff is required to show a picture ID.

Name	Relationship to the child	Home Phone	Work/Cell Phone	Should be called in an emergency	Is authorized to pick up this child
				Yes No	Yes No
				Yes No	Yes No

Persons, other than parents, authorized to pick up the child from First School

Name	Relationship to the child	Phone Number

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Child's Name: _____

MEDICAL INFORMATION: Please fill out the information completely.

Physician's name: _____ Clinic: _____
Address: _____ Telephone: _____
Please list any allergies (including food, seasonal, chemical, animal, etc.) that your child has been diagnosed with: _____
Please list any nutritional or special dietary needs: _____

Please list dates of diagnosis on all that apply: ❑ None

___/___/___ Cancer	___/___/___ Hemophilia	___/___/___ Leukemia
___/___/___ Chicken Pox	___/___/___ Hepatitis B	___/___/___ Measles
___/___/___ Defective Heart	___/___/___ Hepatitis C	___/___/___ Mumps
___/___/___ Diabetes	___/___/___ HIV/AIDS	___/___/___ Tuberculosis
___/___/___ Epilepsy	___/___/___ Hypoglycemia	

Please check all that apply: ❑ None

❑ ADD/ADHD	❑ Frequent colds	❑ Seizures
❑ Bed wetting	❑ Frequent ear infections	❑ Severe Temper tantrums
❑ Biting	❑ Frequent throat infections	❑ Sun sensitivity
❑ Fainting spells	❑ Other: _____	

Emergency Medical/First Aid Consent

I, parent/guardian of _____, request
(Child's first & last name)
and authorize First School or its duly appointed representative to seek emergency medical care for my child. Such care may include transportation to and from the hospital, medical care from a licensed physician if a parent/guardian cannot be reached, as well as first aid treatment by First School staff.

While it is understood that reasonable precautions will be taken by the First School staff to prevent accident or injury to my child while in their care, I will not hold them legally responsible for such accident or injury.

Parent/Guardian Name *(please print)*: _____Date: __/__/__

Parent/Guardian Signature: _____Date: __/__/__