

# Grace Garden Child Development Center

## Enrollment Form

Name \_\_\_\_\_ Gender \_\_\_\_\_ Birth date \_\_\_\_\_

Home Address \_\_\_\_\_ City/Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_

Home Church \_\_\_\_\_ Child Baptized \_\_\_\_\_

When my child is brought to Grace Garden CDC, he/she will be left with a staff member and released only to the parent(s) and/or persons listed below. Grace Garden will not release a child to anyone who is not authorized without prior parent approval. **Verification with a photo i.d. is REQUIRED.**

	Father	Mother
Name	_____	_____
TX Driver's License #	_____	_____
Employer	_____	_____
Work Phone #	_____	_____
Cell Phone #	_____	_____

### EMERGENCY CONTACTS

IN CASE OF EMERGENCY AND I CANNOT BE REACHED, THE FOLLOWING PERSONS MAY BE CONTACTED:  
These persons are also authorized to pick up my child(ren) from child care.

Name \_\_\_\_\_ Phone \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Relationship to Child \_\_\_\_\_ TDL# \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Relationship to Child \_\_\_\_\_ TDL# \_\_\_\_\_

### AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the person in charge to take my child to:

Child' Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Preferred Hospital for Emergency Care \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

ALLERGIES AND/OR SPECIAL MEDICAL CONCERNS \_\_\_\_\_

\_\_\_\_\_

I give consent for this facility to secure any and all necessary emergency medical care for my child.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_