

**Hope School's ESC  
Childcare Program**

**ESC & Sand Dollar Club Registration/Emergency Form**

					DATE CHILD ENTERED CARE	DATE CHILD LEFT CARE
CHILD'S NAME	LAST	FIRST	MIDDLE	NAME USED	BIRTHDATE	
STREET ADDRESS				CITY	ZIP CODE	
CHILD'S PARENT/GUARDIAN'S NAME				HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	
STREET ADDRESS				CITY	ZIP CODE	
WORK ADDRESS (WHERE YOU CAN BE REACHED)				CITY	ZIP CODE	
EMAIL ADDRESS				ALTERNATE EMAIL ADDRESS		
CHILD'S PARENT/GUARDIAN'S NAME				HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	
STREET ADDRESS				CITY	ZIP CODE	
WORK ADDRESS (WHERE YOU CAN BE REACHED)				CITY	ZIP CODE	
<b>OTHER PEOPLE TO NOTIFY IN CASE OF EMERGENCY</b>						
NAME				ADDRESS	TELEPHONE NUMBER	
RELATIONSHIP:					HOME: WORK:	
RELATIONSHIP:					HOME: WORK:	
RELATIONSHIP:					HOME: WORK:	
RELATIONSHIP:					HOME: WORK:	
<b>OTHER THAN YOU, WHO HAS PERMISSION TO PICK UP YOUR CHILD?</b>						
NAME				ADDRESS	TELEPHONE NUMBER	
					HOME: WORK:	
					HOME: WORK:	
					HOME: WORK:	
<b>WHO DOES NOT HAVE PERMISSION TO PICK UP YOUR CHILD?</b>						
NAME				REASON		

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CHILD'S HEALTH INFORMATION		
DATE OF CHILD'S LAST PHYSICAL EXAMINATION:	HEALTH CARE PROVIDER NAME	TELEPHONE NUMBER (AREA CODE)
STREET ADDRESS	CITY	ZIP CODE
SPECIAL HEALTH PROBLEMS	ALLERGIES INCLUDING DRUG REACTIONS	
REGULAR MEDICATIONS	OTHER PERTINENT DATA	
CHILD'S DENTIST'S NAME		TELEPHONE NUMBER (AREA CODE)
STREET ADDRESS	CITY	ZIP CODE

CHILD'S MEDICAL INSURANCE COVERAGE	
INSURANCE COMPANY'S NAME	MEMBER/POLICY NUMBER
POLICY HOLDER'S NAME	EMPLOYER'S NAME
INSURANCE COMPANY'S NAME	MEMBER/POLICY NUMBER
POLICY HOLDER'S NAME	EMPLOYER'S NAME

### CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR CHILDREN

I hereby give permission that my child, \_\_\_\_\_  
 may be given emergency treatment by a qualified child care provider at:  
Hope Lutheran Church & School, 4456 42nd Ave. SW, Seattle, WA 98116  
 NAME AND/OR ADDRESS

When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health. I waive my right of informed consent to such treatment.

I give permission for my child to be transported by ambulance or aid car to an emergency center for treatment

I certify (or declare) under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

PARENT/GUARDIAN'S SIGNATURE	DATE	PARENT/GUARDIAN'S SIGNATURE	DATE
STREET ADDRESS	CITY	ZIP CODE	TELEPHONE NUMBER (AREA CODE)

**\*\* If student is K-6 a \$30.00 Registration Fee, *per family*, must accompany this form to set-up, supply and plan your child's records in ESC licensed childcare program. Monthly rates are on separate sheet. Fees are due with a "ESC Pre-Pay Form" based on your childcare needs. Pre-Pay keeps billing & administrative costs low and keeps ESC properly staffed.**

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