# MORNING STAR COMMUNITY CHRISTIAN CENTER
# CHILDREN'S CHURCH
# REGISTRATION FORM

To be completed by parent(s)/guardian(s) and staff



Today's Date: _____ / _____ / _____

Child's Date of Birth: _____ / _____ / _____ Child's Age: _____ Sex (Circle One): M or F

Name of Child: _____
(First) (Middle Initial) (Last)

Address: _____
(No.) (Street) (City, State, Zip Code)

( _____ ) _____ - _____ ( _____ ) _____ - _____
(Home Phone Number) (Alternate Phone Number)

Mother's Name: _____ Father's Name: _____

| Emergency Contact Information | |
|---|---|
| **Name:** | **Name:** |
| **Address:** | **Address:** |
| | |
| **Phone #** ( ) - | **Phone #** ( ) - |
| **Relationship to Child:** | **Relationship to Child:** |

| NAME OF MEDICAL PROVIDER, CLINIC OR HOSPITAL | |
|---|---|
| **Physician's Name:** | |
| **Address:** | |
| | |
| **Phone #** ( ) - | **Phone #** ( ) - |
| **Name of Primary Insurance Carrier:** (For Insurance Purposes) | **ID or Group Number:** |

**OFFICIAL OFFICE USE ONLY:**

Received by (Please Initial): _____ Checked by Admin: _____
(Please initial)

Date: Date:

# MORNING STAR COMMUNITY CHRISTIAN CENTER
# CHILDREN'S CHURCH
# REGISTRATION FORM

To be completed by parent(s)/guardian(s) and staff



| **Family History** (Check all that apply) | **Allergies** (Check all that apply) |
|---|---|
| ☐ Sickle Cell<br>☐ Diabetes<br>☐ Convulsive Disorder<br>☐ Heart Disease<br>☐ Hypertension<br>☐ Tuberculosis<br>☐ Impaired Vision<br>☐ Impaired Hearing<br>☐<br>☐ | ☐ Medications (specify):<br>☐ Foods (specify):<br>☐ Insect Bites: (specify):<br>Other:<br>☐<br>☐ Reactions (specify): |

| **Hospitalizations and Illnesses** (please respond to each question) | **YES** | **NO** | **EXPLAIN** |
|---|---|---|---|
| Has your child ever been hospitalized or had an operation? | | | |
| Has your child ever had a serious accident (broken bone, head injury, severe fall, burns, poisoning)? | | | |
| Has your child ever had a serious illness? | | | |

| **SPECIAL HEALTH CONDITIONS** | **AGE IT BEGAN** | **TREATMENT/MEDICTIONS ADMINISTERED** |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

**CONSENT FOR EMERGENCY MEDICAL TREATMENT** (Required for admission to the Child Care Ministry)

I do hereby give authorization to Morning Star Community Christian Center Child Care Staff to obtain the necessary emergency medical treatment for my child, with the understanding that the family will be notified as soon as possible.

**SIGNED** _____ **DATE** _____

**RELATIONSHIP** _____

**OFFICIAL OFFICE USE ONLY:**

Received by (Please Initial): _____ Checked by Admin: _____ (Please initial)