

FAITH & PATIENCE DAYCARE
SUMMER PROGRAM



Child's Information:

Full Name: _____ D.OB _____

Address: _____

Parent/Guardian Information

Mother's Name: _____

Address: _____

Home Phone: _____ Work: _____

Employer: _____

Supervisor: _____

Father's Name: _____

Address: _____

Home Phone: _____ Work: _____

Employer: _____

Supervisor: _____

Emergency Contacts (The persons below may be contacted in the event of an emergency)

1.) Name: _____

Relationship: _____

Address: _____

Home phone: _____ Cell: _____

2.) Name: _____

Relationship: _____

Address: _____

Home phone: _____ Cell: _____

Pick-UP Authorization

1.) Name: _____
Relationship: _____
Address: _____
Home phone: _____
Cell: _____

2.) Name: _____
Relationship: _____
Address: _____
Home
phone: _____ Cell: _____

Authorization for Emergency Medical Care

I understand **that I will** be notified at once in case of accident or illness to my child, and I give my permission for my child to be treated at:

Carolina Medical Center University
8800 N. Tryon Street
Charlotte, NC. 28262
704-548-6000

Sign: _____