Quick Form

ALL MY CHILDREN DAY CARE AND LEARNING CENTER
644 WINDY HILL ROAD
SMYRNA. GA 30080

Date:_____

CHILD'S NAME _____
BIRTH DATE _____ AGE _____ SEX _____ RACE _____
HOME ADDRESS _____
CITY _____ ZIP _____ HOME PHONE _____
MOTHER'S NAME _____
MOTHER'CELL/PAGER # _____ WORK PHONE_____
FATHER'S NAME _____
FATHER'S WORK PHONE # _____ CELL/PAGER # _____
LIST ADULTS FULL NAMES AND PHONE # FOR EMERGENCY PICK-UP.
1. _____Phone_____
2. _____Phone_____
3. _____Phone_____
4. _____Phone _____
DOES YOUR CHILD HAVE ANY MEDICAL CONDITION WE SHOULD BE AWARE OF? _____. IF YES , EXPLAIN _____

_____

MY CHILD IS ALLERGIC TO _____. Attached is a doctor's statement for confirmation and the Center record.
CHILD'S DOCTOR'S NAME _____
ADDRESS _____
PHONE NUMBER _____

Yes No - All My Children Day Care And Learning Center is given my permission to provide field trips for my child and is absolved of any legal responsibility in case of an accident. (You will be given notification of all trips.

Yes No - I give my permission for my child to be photographed for identification, publicity and educational purpose. My child photograph may appear in a newspaper.

Yes No - All My Children Day Care And Learning Center has my permission to secure emergency medical attention for my child.

I, _____ have read or had been read to me and I understand the All My Children Day Care And Learning Center policies and procedures.

_____ _____
Signature of Parent / Guardian AMCDC&LC Registration Personnel.
Date _____ Date