

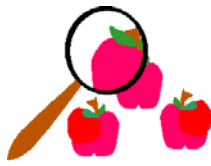
Allergies:

(indicate if none)

Epipen? Yes No

(circle one)

protocol must be provided  
signed by doctor and  
parent if "yes"



Other Medical Alerts:

(indicate if none) protocol  
must be provided and  
signed by doctor and  
parent if needed

## Classroom of Discovery Registration Form

This form along with: (a) emergency contact form [[http://www.dss.state.va.us/form/pdf/cdc\\_medical.pdf](http://www.dss.state.va.us/form/pdf/cdc_medical.pdf)] and (b) Commonwealth of Virginia (green) medical form are required [for child to enter classroom](http://www.vahealth.org/schoolhealth/mch213d.pdf). [<http://www.vahealth.org/schoolhealth/mch213d.pdf>]

Please fill in each blank. If something is not applicable, please indicate with "n/a" or "none."

Child's Last Name \_\_\_\_\_ any suffix (e.g. Jr.) \_\_\_\_\_

Child's First Name \_\_\_\_\_ Child's Middle Name \_\_\_\_\_

Child's Nickname \_\_\_\_\_ Child's Birthdate \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Mom's Full Name \_\_\_\_\_

(if you prefer to be called by other than your first name, please indicate: \_\_\_\_\_)

Address & Home Phone if different from child's: \_\_\_\_\_

Dad's Full Name \_\_\_\_\_

(if you prefer to be called by other than your first name, please indicate: \_\_\_\_\_)

Address & Home Phone if different from child's: \_\_\_\_\_

Other Contact Info:

Preferred email address: \_\_\_\_\_

Mom's work: \_\_\_\_\_ Mom's cell: \_\_\_\_\_

Mom's place of work & address: \_\_\_\_\_

Dad's work: \_\_\_\_\_ Dad's cell: \_\_\_\_\_

Dad's place of work & address: \_\_\_\_\_

If mom or dad cannot be reached, please call to pick up my child (minimum two required):

(1) \_\_\_\_\_ relationship: \_\_\_\_\_ phone: \_\_\_\_\_ address: \_\_\_\_\_

(2) \_\_\_\_\_ relationship: \_\_\_\_\_ phone: \_\_\_\_\_ address: \_\_\_\_\_

(3) \_\_\_\_\_ relationship: \_\_\_\_\_ phone: \_\_\_\_\_ address: \_\_\_\_\_

Please note any others authorized to pick up your child:

Please turn this form over and continue. Thank you.

The school has my permission in an emergency when I or my physician cannot be contacted to take my child to the emergency room of the nearest hospital, and the hospital and its medical staff have my authorization to provide treatment which a physician deems necessary for the well-being of my child.

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

I give permission for my child to take walking field trips to Briar Patch Park during school hours. I will provide permission on a case-by-case basis for additional field trips throughout the year.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Schools attended prior to the Classroom of Discovery: \_\_\_\_\_

Other requested information:

Child's favorite activities: \_\_\_\_\_

Child's least favorite activities: \_\_\_\_\_

Any special toileting routines: \_\_\_\_\_

Child's siblings, genders and ages (if any): \_\_\_\_\_

Parents' occupations (as far as child is concerned - not necessarily real job title; we may use this information in class discussions): \_\_\_\_\_

Pets? (names, types, etc. - again for class discussion purposes): \_\_\_\_\_

Is there anything else we should know about your child?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Birth Certificate Information (to be recorded by STAFF ONLY) - NOT REQUIRED FOR CONTINUING STUDENTS**

Place of Birth:	Birth Date:	Birth Certificate #:
Other Form of Proof		Date Issued:
Date Documentation Viewed:		Person Viewing Documentation:
Date of Notification of Local Law Enforcement (when proof not provided):		

The Classroom of Discovery admits children without regard to race, religion, cultural heritage, political beliefs, disability, marital status of family, family life style or national origin.

For office use:  
Date started CoD: \_\_\_\_\_  
Date left CoD: \_\_\_\_\_

For Office Use:  
Check # \_\_\_\_\_ Amount \$ \_\_\_\_\_  
Data Entered