

First Baptist Christian School
STUDENT INFORMATION SHEET
After School Care

Circle day(s) attending: All Mon Tues Wed Thurs Fri

Approximate time of pick-up: _____ Picked up by: _____

Student Name: _____

Grade: _____ Birthdate: _____ Home phone: (____) _____

Home Address: _____
street *city/town* *zip*

Father's Name: _____
first *m.i.* *last*

Business: _____ Title: _____

Work Address: _____
street *city/town* *zip*

Work Phone: (____) _____ X _____ Cell Phone: (____) _____

Mother's Name: _____
first *m.i.* *last*

Business: _____ Title: _____

Work Address: _____
street *city/town* *zip*

Work Phone: (____) _____ X _____ Cell Phone: (____) _____

Please describe any medical or allergy related conditions (including insect bites) and what special prescription medicines may need to be administered at the school. Also list any restrictions regarding physical activities.

Hospital Preference: _____

Is there anyone we should **NOT** dismiss your child to? _____

Emergency Contacts:

1. _____
name *relationship* *phone*

2. _____
name *relationship* *phone*