



CtR GENESIS ECP CHILD ADMISSION FORM 2022-2023

CAF - 1

CHILD'S NAME: _____
First Middle Last Sex

Name child goes by: _____ Age: _____ (as of September 1, 2022)

Date of Birth: _____ Subdivision: _____

Child's Address: _____

City: _____ State: _____ Zip Code: _____

HOURS AND DAYS CHILD WILL BE IN CARE: (All classes are 9:00 am – 2:00 pm)

18 mo. olds: Tues/Thurs Mon/Wed/Fri M-F

2 year olds: Tues/Thurs Mon/Wed/Fri M-F

3 year olds: Tues/Thurs Mon/Wed/Fri M-F

4 year olds: Tues/Thurs Mon/Wed/Fri M-F

Do you have any older siblings that will attend CtR Catholic School? (Pre-K – 8th) Yes No

MOTHER/GUARDIAN NAME: _____

Mother's E-mail: _____ Cell Phone: _____

Address (if different from child): _____

Employer: _____ Work Phone: _____

CtR Parishioner: Yes No If yes, Parish I.D. #: _____

FATHER/GUARDIAN NAME: _____

Father's E-mail: _____ Cell Phone: _____

Address (if different from child): _____

Employer: _____ Work Phone: _____

CtR Parishioner: Yes No If yes, Parish I.D. #: _____

EMERGENCY CONTACT PERSONS: (Other than parents) Additional persons other than parents to contact in an emergency with authorization to pick up when parent cannot be reached.

Name (1): _____ Relationship: _____

Address: _____ City: _____ Zip: _____

Best Contact Phone #: _____ Alternate Phone #: _____

Name (2): _____ Relationship: _____

Address: _____ City: _____ Zip: _____

Best Contact Phone #: _____ Alternate Phone#: _____

CHILD'S NAME: _____

ADDITIONAL PERSONS TO WHOM THE CHILD MAY BE RELEASED: (Only if needed)

Name (3): _____ Relationship: _____

Best Contact Phone #: _____ Alternate Phone#: _____

Name (4): _____ Relationship: _____

Best Contact Phone #: _____ Alternate Phone#: _____

Primary language spoken in the home? _____

Previous preschool or daycare attended? _____ Potty Trained: Yes No

Physician diagnosed food allergies: Yes No If yes, please list specific foods that your child **CANNOT** have: (A physician must complete a **Food Allergy Plan** for any diagnosed food allergies – see Form 6)

For food allergies, please list snacks safe for your child to eat: _____

Other food sensitivities/intolerances, or seasonal, drug, or bite allergies: _____

Medications (i.e.: Inhalers, Epi Pen): _____

Please initial: I understand that the annual tuition is set for the year and divided into nine equal monthly payments due September through May on the first school day of each month. Furthermore, I understand that the Registration Fee (**which is NON-REFUNDABLE**) is due with the registration form to secure a place for my child in the program.

Please initial: I give permission for my child to participate in all water activities throughout the year which may include water tables, water sprinklers, small water slides and wade pools.

IN THE EVENT I CANNOT BE REACHED TO MAKE ARRANGEMENTS FOR EMERGENCY MEDICAL CARE FOR MY CHILD AT THE TIME OF AN ILLNESS OR ACCIDENT, I AUTHORIZE CTR GENESIS ECP AND ITS STAFF TO OBTAIN ANY NECESSARY EMERGENCY MEDICAL CARE AT THE NEAREST FACILITY.

Parent Signature: _____ Date: _____

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PLEASE DO NOT FILL IN THIS SECTION

Date of Registration: _____ Amount \$ _____ Check # _____

Start Date: _____ Date of Termination: _____

Reason for Withdrawal: _____

Comments: _____