Greenwood United Methodist Church
Greenwood Learning Center

Please return your completed application, along with a $50 registration fee, to
Greenwood United Methodist Church
10040 Greenwood Road
Glen Allen, VA 23060

Child's Full Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Grade: _____School Attending:_____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: (Home)_____ (Cell)_____

Mother's Name: _____Phone: _____

Employer: _____Phone: _____

Occupation: _____

Father's Name: _____Phone: _____

Employer: _____ Phone: _____

Occupation: _____

Email Address: _____

Names & Ages of Siblings: _____Age: _____

_____Age: _____

_____Age: _____

Church Affiliation (Optional): _____

How did you hear about the Greenwood Learning Center? _____

Persons Authorized to Pick Up My Child: _____

_____

_____

Parent signature: _____Date: _____

Greenwood Learning Center

Health & Emergency Information Record

Child's Name: _____

Date of Birth _____ Home Phone _____

Mother's Name: _____

Father's Name: _____

Does your child have any long-term medical conditions that will affect his/her daily routine?

_____

_____

Does your child have: Frequent colds? _____ Earaches? _____ Stomach aches? _____

Asthma? _____ Hives? _____ Allergic to bee stings? _____ Other _____

Does your child have any food allergies? _____

Other allergies? _____

What symptoms appear related to this allergy? _____

Child's Health Care Provider: _____ Phone: _____

Address: _____

Hospital Preference: _____

Date of last Tetanus booster: _____

Insurance Company: _____

Policy #: _____

Persons to Contact if Parents are Unavailable:

Name: _____ Relationship to Child: _____

Address: _____ Phone: _____

Name: _____ Relationship to Child: _____

Address: _____ Phone: _____

In the event that I cannot be reached, I hereby give my permission for my child to receive any necessary emergency medical care or treatment. I understand that every effort will be made to contact me or my spouse before such action is taken. I will be responsible for the payment of such care or treatment.

Parent signature: _____ Date: _____

Parent Printed Name: _____