First Metropolitan Infant Development Center & Christian Academy

ENROLLMENT INFORMATION

Child's Name:	**Date of Birth:**	**Sex:**
Child's Address:		
Date of Admission:		
Hours and Days Child Will be in Care:		

PARENT/GUARDIAN INFORMATION

Parent/Guardian with whom the student lives:

Last Name:	**First Name:**	**Relationship:**
Address:		
Home Phone:	**Cell Phone:**	
Place of Employment:	**Work Phone:**	

Additional Parent/Guardian Information:

Last Name:	**First Name:**	**Relationship:**
Address:		
Home Phone:	**Cell Phone:**	
Place of Employment:	**Work Phone:**	

FAMILY INFORMATION

Please list all brother/sisters at the same address:

Name	Gender	Date of Birth	Age	School (if any)

AUTHORIZED PICK-UP & EMERGENCY CONTACTS

Name:		**Texas Driver's License #**	
Relationship:	**Work Phone:**	**Home Phone:**	**Cell Phone:**
Name:		**Texas Driver's License #**	
Relationship:	**Work Phone:**	**Home Phone:**	**Cell Phone:**
Name:		**Texas Driver's License #**	

First Metropolitan Infant Development Center and Christian Academy
8870 West Sam Houston Parkway North, Houston Texas 77040
Phone: (713) 983-6403
Fax: (713) 983-7888

Relationship:	Work Phone:	Home Phone:	Cell Phone:
Name:		Texas Driver's License #	
Relationship:	Work Phone:	Home Phone:	Cell Phone:

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take my child to:

Name of Licensed Physician:	Address:	Phone:
Name of Hospital/Clinic:	Address:	Phone:
I give consent for this facility to secure any and all Necessary emergency medical care for my child.	Signature- Parent or Legal Guardian	

I certify that the information that I provided on this form is accurate:

_____ _____

Parent/Guardian Date