CtR GENESIS ECP
CHILD ADMISSION FORM
2021-2022

CAF - **1**

CHILD'S NAME: _____ _____
First Middle Last Sex

Name child goes by: _____ Age: _____ (as of September 1, 2021)

Date of Birth: _____ Subdivision: _____

Child's Address: _____

City: _____ State: _____ Zip Code: _____

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

18 mo.-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 ☐ 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 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.

_____ Please initial:

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.

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: _____

PLEASE DO NOT FILL IN THIS SECTION

Date of Registration: _____ Amount $_____ Check # _____

Start Date: _____ Date of Termination: _____

Reason for Withdrawal: _____

Comments: _____