



Enrollment Form

_____ *Last Name, First Name*

FAMILY INFORMATION

Date: _____

Student's Name: _____ Nickname (if any): _____

Student's Birth Date: ____ - ____ - ____ Male: _____ Female: _____

Primary Contact	Secondary Contact
Name: _____	Name: _____
Relationship to child: _____	Relationship to child: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Student lives at this address: ____ Yes ____ No	Student lives at this address: ____ Yes ____ No
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____
Work Phone: _____	Work Phone: _____
Employer: _____	Employer: _____
Work Address: _____	Work Address: _____
City, State, Zip: _____	City, State, Zip: _____
Member of WOLCC? ____ Yes ____ No	Member of WOLCC? ____ Yes ____ No
Email Address: _____	Email Address: _____

Periodically Word of Life Academy may send out an email blast. Please indicate whether or not you are interested in being on our list. <input type="checkbox"/> I want to be on the list <input type="checkbox"/> I don't want to be on the list	Periodically Word of Life Academy may send out an email blast. Please indicate whether or not you are interested in being on our list. <input type="checkbox"/> I want to be on the list <input type="checkbox"/> I don't want to be on the list
Periodically Word of Life Academy may sent out an automated phone call. Which number is the best way to contact you? <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Periodically Word of Life Academy may sent out an automated phone call. Which number is the best way to contact you? <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work

How did you hear about us?
 Phone Directory NAEYC Website Other Website: _____
 WOLCC Event: Service / VBS / Easter Egg Hunt / Harvest Carnival / Other: _____
 Referral – Whom may we thank? _____

For Administrative use only- _____ \$75.00 Reg. fee _____ Class Placement
 Date: _____ Time: _____ Taken by: _____



Last Name, First Name

STATEMENT OF AUTHORIZATION

Please initial the following:

_____ My child has permission to watch taped educational TV programs and videos as the Word or Life Academy teachers deem appropriate.

_____ My child has permission to go on supervised walking field trips away off of school property. Notice will be given for field trips further than one mile from the school.

_____ I give permission for the use of any photograph or video representation of my child/children in news releases, brochures, or for other public relations purposes.

Emergency Contact Information

In the event of illness or an emergency, we will try to contact a parent first. If we are unable to reach either parent, we will attempt to call a contact listed below. Please list anyone you would like for us to contact, and include any persons that might pick up your child for carpool, or in the event of illness or an emergency.

Order of Preference	Name	Phone Number	Address	Relationship to Student	Authorized for pick up?
1					
2					
3					
4					
5					

Only those persons marked are authorized to pick up my child from school. I understand that my child will not be released to anyone on this form without prior consent. In the event of an emergency, I can give verbal authorization to the school to add a person to this form, who will then be required to show proof of identification.

 Parent Signature

 Date



_____ *Last Name, First Name*

MEDICAL INFORMATION

Doctor's Name: _____

Name of Practice: _____

Address: _____

Phone Number: _____

Dentist's Name: _____

Name of Practice: _____

Address: _____

Phone Number: _____

Please list any allergies or medical concerns:

If my child needs emergency, medical attention, my child should be take to the following hospital:

_____ **Children's Hospital**

1056 E. 19th Avenue
Denver, CO 80218
303-861-8888

_____ **Porter Adventist Hospital**

2525 S. Downing
Denver, CO 80210
303-778-1955

_____ **Parker Adventist Hospital**

9395 Crown Crest Blvd.
Parker, CO 80138
303-269-4000

_____ **Swedish Medical Center**

501 E. Hampden Avenue
Englewood, CO 80110
303-788-5000

_____ **Skyridge Medical Center**

10101 Ridgeway Parkway
Lone Tree, CO 80124
720-225-1000

_____ **Littleton Adventist Hospital**

7700 S. Broadway
Littleton, CO 80122
303-730-8900

_____ **Other** (please list name, address, phone number below):

_____ **No Preference**

I hereby give permission to Word of Life Academy to call an emergency team, doctor or other medical person or organization or surgical care for my child or to have my child taken to a hospital should the need arise. If time permits, I understand that an effort will be made to locate me or my spouse before any action will be taken. If we cannot be contacted, any expense incurred by the school will be accepted by the undersigned.

Parent Signature

Date