PARENTS: To complete this DHHS registration, we will need:

_____ Registration form

_____ Student Information Sheet

_____ Current physical exam

_____ Immunization certificate

Check all that apply for your student

____ 3 YO Preschool

____ 4 YO Preschool

_____ Part Time Wrap Around Care (Less than 20 hours a week)

_____ Full Time Wrap Around Care (More than 20 hours a week)

2025-2026

JFK Childcare **Preschool** Program Registration Form

One form is required for each child.

Child's Name_____ Birthdate_____ Grade_____

Address_____
Street Address City State Zip Code

Parent/Guardian Name(s)_____

Mother's Cell Phone_____ Father's Cell Phone_____

Mother's Work Phone_____ Father's Work Phone_____

Mother's E-mail_____ Father's E-mail_____

I understand that school rules and policies of JFK School apply to students enrolled in JFK Child Care Services.

I understand and agree that the violation of these rules and policies and/or non-payment of childcare fees may result in my child not being allowed to attend the childcare programs at John F. Kennedy School.

I understand that access to childcare may be terminated for any family who fails to pay for childcare services.

Parent Signature_____ Date_____

_____ Date: _____

Signature: JFK Principal/Director of JFK Child Care Services

JFK CHILDCARE PRESCHOOL STUDENT INFORMATION FORM
WITH EMERGENCY MEDICAL CONSENT

CHILD'S NAME:		**BIRTH DATE:**
PARENT(S)/GUARDIAN(S) WITH WHOM THE CHILD RESIDES		
1. NAME		RELATIONSHIP TO CHILD
ADDRESS		EMAIL
HOME NUMBER	CELL NUMBER	WORK NUMBER
2. NAME		RELATIONSHIP TO CHILD
ADDRESS		EMAIL
HOME NUMBER	CELL NUMBER	WORK NUMBER
EMERGENCY CONTACTS/PERMISSION TO PICK UP – INCLUDE YOURSELF		
1. NAME		☐ EMERGENCY CONTACT AND PICK UP ☐ PICK UP ONLY
HOME PHONE	CELL PHONE	WORK PHONE
2. NAME		☐ EMERGENCY CONTACT AND PICK UP ☐ PICK UP ONLY
HOME PHONE	CELL PHONE	WORK PHONE
3. NAME		☐ EMERGENCY CONTACT AND PICK UP ☐ PICK UP ONLY
HOME PHONE	CELL PHONE	WORK PHONE
4. NAME		☐ EMERGENCY CONTACT AND PICK UP ☐ PICK UP ONLY
HOME PHONE	CELL PHONE	WORK PHONE
5. NAME		☐ EMERGENCY CONTACT AND PICK UP ☐ PICK UP ONLY
HOME PHONE	CELL PHONE	WORK PHONE

Is there a custody or restraining order for persons who may attempt to pick the child up? ☐ **YES** ☐ **NO**

If YES, please supply the name(s) below and a copy of the court order restraining the individual(s).

Name	**Name**

PHYSICIAN NAME	**DENTIST NAME**
PHONE NUMBER	PHONE NUMBER
ADDRESS	ADDRESS
HOSPITAL PREFERENCE	
KNOWN ALLERGIES	
DAILY MEDICATION	
INSURANCE PROVIDER	**POLICY IDENTIFICATION NUMBER**

This form allows parents and guardians to authorize the provision of emergency treatment for below named child who becomes ill or injured while under program authority when parents or guardians cannot be reached. In the event reasonable attempts to contact have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by the doctor or dentist listed below, or if unavailable, another licensed physician or dentist.

I agree to pay all costs and fees as secured or authorized under this consent.

This consent will be in effect for one year, beginning on the date signed, and updated annually thereafter.

_____

SIGNATURE OF PARENT OR GUARDIAN **PRINTED NAME** **DATE**