

Grade: _____	Teacher: _____
Enrollment Date: _____	
DOB: _____	
Hrs/Days in Care: _____	

Mt. Franklin Christian Academy

201 E. Sunset Rd. El Paso, TX 79922 915-581-4487 (fax 915-581-0331)

STUDENT INFORMATION

Revised 2/3/06

Student Name _____			
(Last)	First	Middle	(Prefers to be Called)
Address: _____		Zip Code: _____	Home Phone: _____
Date of Birth: / /	Place of Birth: _____	Age: _____	Grade: _____
Social Security Number: _____		is child a US citizen? If NO, explain	

PARENTS OR GUARDIANS

Address correspondence to:

Child resides with:	<input type="checkbox"/> Mother/Father	<input type="checkbox"/> Mother Only	<input type="checkbox"/> Father Only
	<input type="checkbox"/> Mother/Step-Father	<input type="checkbox"/> Father/Step-Mother	<input type="checkbox"/> Guardian
Father's Name _____	Mother's Name _____		
Address _____	Address _____		
Occupation _____	Occupation _____		
Employer _____	Employer _____		
Business Phone _____	Business Phone _____		
Cell Phone _____	Cell Phone _____		
(e-mail address)	(e-mail address)		
If not living with parents, please fill in Guardian Information:			
Guardian's Name _____	Employer _____		
Address _____	Business Phone _____		
Home Phone _____	Cell Phone _____		

EMERGENCY CONTACT INFORMATION: When a parent cannot be reached, call:

Name _____	Relationship _____	Telephone # _____
Name _____	Relationship _____	Telephone # _____

MEDICAL INFORMATION:

Does your child have any allergies? _____ If YES, WHAT? _____

Is your child taking any medication prescribed for long term use? _____ If YES, please list: _____

Does your child have any existing illness, previous serious illness, or injuries during the past 12 months? _____ If YES, please describe in space below.

Does your child have any physical, mental or emotional limitations or needs which may effect activities or progress? _____ If YES, please describe below.

Does your child have any special problems, fears or anxieties that the staff should be aware of? _____ If YES, please describe below.

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 _____	Telephone # _____
Name of Hospital/Clinic _____	Address _____	Telephone # _____

I give consent for necessary emergency treatment when my child is in the care of this physician and/or hospital/clinic. _____

Signature or Parent/Guardian