A MINISTRY OF SPRINGFIELD UNITED METHODIST CHURCH

REGISTRATION 2024-2025

NAME OF CHILD_____
LAST FIRST MIDDLE

DATE OF BIRTH_____ NICKNAME_____BOY_____GIRL_____

ADDRESS_____

CITY & ZIP CODE_____

PARENT #1_____CONTACT PHONE_____

RELATIONSHIP TO CHILD _____ EMAIL_____

OCCUPATION_____ CITY OF EMPLOYMENT_____

PARENT #2_____CONTACT PHONE_____

RELATIONSHIP TO CHILD _____ EMAIL_____

OCCUPATION_____ CITY OF EMPLOYMENT_____

NAMES AND AGES OF SIBLINGS_____

EMERGENCY CONTACTS: Name of a relative, friend, or otherwise responsible person to contact in case parents cannot be reached. Emergency contacts must live locally. All Emergency Contacts are automatically authorized to pick up the child at any time.

1._____ PHONE_____

2._____ PHONE_____

3._____ PHONE_____

PHYSICIAN'S NAME_____PHONE_____

ALLERGIES/MEDICAL CONDITIONS _____

SIGNATURE OF PARENT_____ DATE_____

7047 Old Keene Mill Road, Springfield, VA 22150
703-569-3479
www.christianweekdayprogram.org
christianweekday@gmail.com

Room # _____
# of Days _____
Start Date _____