

Semester _____ Year _____

(Parent's Name)	(Student Number)
(Address)	(Home Phone)
(Work Place)	(Work Phone)

The following people are authorized to pick up your child at the Child development Center: (Phone # must be included)

(Name)	(Phone Number)
(Name)	(Phone Number)
(Name)	(Phone Number)
(Name)	(Phone Number)

(Child's Name)

In an emergency, school closing, and/or illness when I cannot be reached, please call: (Make it someone local please)

(Name)	(Relationship to Child)
(Address and Phone)	
(Name)	(Relationship to Child)
(Address and Phone)	

Any Special Comments or Medical Concerns:

Please fill in your schedule for each day with classroom number and building or workplace. Please add phone numbers wherever possible. We also need to know where/how to locate you in between classes.

Time	Monday	Tuesday	Wednesday	Thursday	Friday
8:00					
9:00					
10:00					
11:00					
12:00					
1:00					
2:00					
3:00					
4:00					
5:00					
6:00					
7:00					
8:00					
9:00					
10:00					

