

Reagan Colley, Director

FAMILY OF CHRIST  
FOC AfterSchool Registraton  
16190 Bruce B. Downs Blvd. Tampa, FL 33647  
813-558-9343

David Haara, Pastor

CHILD'S NAME \_\_\_\_\_

SEX \_\_\_\_\_ BIRTHDAY \_\_\_\_\_ CHILD'S SSN# \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ ZIP CODE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_

Driver's License# \_\_\_\_\_ CELL PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

Email Address \_\_\_\_\_

FATHER'S NAME \_\_\_\_\_

Driver's License# \_\_\_\_\_ CELL PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

Email Address \_\_\_\_\_

Parties authorized to 1) Remove child from our center; 2) Be called in a medical emergency:

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

We will not release your child to anyone without your written or verbal permission. They must present proper photo identification.

**Current marital status of parents:** Single Married Divorced Separated Joint Custody

(Please attach copies of court documents defining custody if applicable.)

**IN CASE OF EMERGENCY/MEDICAL INFORMATION**

**PARENTS ARE RESPONSIBLE FOR MEDICAL COVERAGE FOR THEIR CHILD SHOULD INJURY OCCUR ON THE FAMILY OF CHRIST PREMISE OR AT ANY OFF-PREMISE FUNCTION.**

**If my child should become ill or injured at your center, I understand that Family of Christ CDC will:**

1) Contact me immediately, 2) contact the persons I have designated above if I cannot be reached. Should Family of Christ CDC be unable to reach me and/or persons designated above, they are authorized to contact my child's physician and/or arrange for emergency treatment. The physician and/or medical facility are authorized to administer emergency medical treatment necessary for the health and safety of my child. I will be responsible for payment of medical services rendered.

Date \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOSPITAL PREFERENCE \_\_\_\_\_

MEDICAL INSURANCE \_\_\_\_\_ POLICY # \_\_\_\_\_

ALLERGIES OR PERTINENT INFORMATION \_\_\_\_\_

START DATE: \_\_\_\_\_ Grade entering \_\_\_\_\_

Please read & sign back of form.

**FEES**

**I UNDERSTAND THAT REGISTRATION FEES ARE NON-REFUNDABLE.**

I understand that all tuition payments are processed through Tuition Express, an automated payment processing system. Monthly tuition will be processed on the 15<sup>th</sup> of each month.

A \$5 processing fee per month will be charged for all non-Tuition Express accounts. Payment must be made in cash or by money order. **NO CHECKS WILL BE ACCEPTED.** A \$20 late fee will be applied for all payments received after the 15<sup>th</sup> (regardless of attendance dates).

Returned Tuition Express payments will be assessed a \$20 fee. If two or more payments are returned for nonpayment, you may be required to pay in cash or money order (subject to the above fees) or your child(ren) may be withdrawn from our program.

Date \_\_\_\_\_ Signature of Parent/Guardian\_\_\_\_\_

**Registration Fee**

\_\_\_\_\_ Yes. I would like to have the \$85 registration fee taken out of Tuition Express (check space)

**Know Your Child's Daycare**

Hillsborough County Ordinance 90-38, Section 5.09 requires that parents must receive a copy of the childcare facility brochure, Know Your Child's Daycare. The parent's/guardian's signature verifies receipt of the brochure.

Date \_\_\_\_\_ Signature of Parent/Guardian\_\_\_\_\_

\*Family of Christ follows the Hillsborough County School schedule for days off and dismissal. We run programs when the public schools are out. The fees differ if there are half days or full days. Please watch for notices of registration.

\*Family of Christ Child Development Center admits students of any race, color, national or ethnic origin.

**Please Select:**

**2 Day After Care**\_\_\_\_\_

**3 Day After Care** \_\_\_\_\_

**5 Day After Care** \_\_\_\_\_

**3 Day Before and After Care** \_\_\_\_\_

**5 Day Before and After Care** \_\_\_\_\_