Registration Fee _____ 2 3 4

(Office Use Only)

# Little Hearts School

1004 S. Story Road
Irving, Texas 75060
Phone: 972-790-3629, ext. 229
Fax: 972-790-3630

Child's Name _____ Name Used _____
Birth Date ___/___/___ Age on September 1 _____ Male/Female
Personality Traits _____
What language is spoken at home? _____
If a new student, previous schooling experiences _____

Address _____
Phone (_____) _____ City State Zip

Father's Name _____
Place of Employment _____Occupation _____
Home Address _____
(If different from your child's) City State Zip
Phone Numbers: Home (___) _____ Work (___) _____
Cell (___) _____ Pager (___) _____
Email Address _____

Mother's Name _____
Place of Employment _____Occupation _____
Home
Address_____
(If different from your child's) City State Zip
Phone Numbers: Home (___) _____ Work (___) _____
Cell (___) _____ Pager (___) _____
Email Address _____

Daytime Caregiver _____ Relationship _____
Phone Numbers: Home (___) _____ Cell (___) _____

In case of an emergency when parents and/or caregiver cannot be reached, please call:
Name _____ Relationship _____ Phone (___) _____
Name _____ Relationship _____ Phone (___) _____
Name _____ Relationship _____ Phone (___) _____

Child's Doctor _____ Phone (___) _____
Medical Conditions/Medications _____
Known Allergies _____

How did you become aware of Little Hearts School _____

# Please attach a current copy of your child's Immunization Record.

I, _____, authorize any representative of Little Hearts School to seek any and all necessary medical treatment needed for_____. I understand that an effort will be made to contact me concerning such needed treatment as soon as is practical and that I will be financially responsible for said treatment.

I affirm that I have full legal authority to consent for his/her medical treatment.

_____ _____
Signature of Parent/Guardian Date

_____
Relationship

I, _____, consent to the release of any photographs of _____ for the use of promotion for Little Hearts School.

_____ _____
Signature of Parent/ Guardian Date

_____
Relationship

I, _____, give my permission for Little Hearts School to release _____ to the following people.

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

The following people may **NOT** pick up my child.

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

_____ _____
Signature of Parent/Guardian Date

_____
Relationship

If an individual is not listed on the above release, we must have written or verbal permission from you in order to release your child. Please, be sure to have anyone picking up your child bring in their driver's license so that we can verify their identity.