

Preschool students

1 YEAR OLD Class \* MUST BE 1 and walking BY Sept. 1st

Turtles

2 year old classes \* MUST BE 2 BY Sept. 1st

Seahorse/starfish

3 YEAR OLD cLASSES \* MUST BE 3 BY Sept. 1st

SAND DOLLAR/DOLPHIN

Kindergarten READINESS-4/5 YEAR OLD Classes \* MUST BE 4 BY Sept. 1st

Stingray/Manatee

Child’s Information

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CHILD’S LAST NAME FIRST NAME MI

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NICKNAME DATE OF BIRTH

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PARENT/GUARDIAN NAME(S)

M T W TH

\*\* DAYS ATTENDING - CHECK ALL APPLICABLE DAYS

How Did you hear about us?

☐ SIGN ☐ WEB ☐ CHURCH ☐ REFFERAL BY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2022-2023

APPLICATION



**** FIRST RESPONDER  MILITARY  SIBLING

Family Information

Child’s Medical Information

Emergency contact/Child Pickup

Parent/Guardian Signature

FAMILY Information

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT/GUARDIAN 1 OCCUPATION COMPANY

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STREET ADDRESS CITY, STATE, ZIP CODE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL PHONE 1 PHONE 2

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PARENT/GUARDIAN 2 OCCUPATION COMPANY

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STREET ADDRESS (IF DIFFERENT FROM ABOVE) CITY, STATE, ZIP CODE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL PHONE 1 PHONE 2

CHILD’S MEDICAL Information

I HEREBY RELEASE LIFESONG CHURCH, ITS STAFF AND SPONSORS FROM RESPONSIBILITY AND LIABILITY FROM ANY INJURY OR ILLNESS THAT MY CHILD MAY SUSTAIN DURING THE SEASON IN WHICH I HAVE ENROLLED MY CHILD. IN THE EVENT OF AN EMERGENCY, I HEREBY AUTHORIZE ANY STAFF MEMBER AS AN AGENT FOR ME, TO CONSENT TO ANY X-RAY, EXAMINATION, MEDICAL, DENTAL, OR SURGICAL DIAGNOSIS; TREATMENT AND HOSPITAL CARE ADVISED AND SUPER STATE WHERE THE SERVICES ARE RENDERED, EITHER AT A DOCTOR’S OFFICE OR ANY HOSPITAL. EVERY EFFORT WILL BE MADE TO CONTACT THE PARENT AS SOON AS POSSIBLE. AND THESE POWERS WILL ONLY BE USED IF ATTEMPTS TO CONTACT A PARENT/GUARDIAN ARE UNSUCCESSFUL.

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DOCTOR’S NAME PHONE #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STREET ADDRESS CITY, STATE, ZIP

PLEASE LIST ANY ALLERGIES, SPECIAL MEDICAL/DIETARY NEEDS, OR AREAS OF CONCERN:

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Tuition and discounts

WE OFFER A 5% DISCOUNT TO SIBLININGS, FIRST RESPONDERS, AND MILITARY FAMILIES. PLEASE INDICATE HERE IF YOU MEET ONE OF THESE QUALIFICATIONS (ONE DISCOUNT PER FAMILY).

PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT SIGNATURE DATE

\*\* PLEASE NOTE WE HAVE A NOTARY ON STAFF

SWORN TO (OR AFFIRMED) AND SUBSCRIBED BEFORE ME ON THIS \_\_\_\_\_\_\_\_ DAY OF \_\_\_\_\_\_\_\_\_\_ OF \_\_\_\_\_\_\_\_\_\_\_

(DAY) (MONTH) (YEAR)

BY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(NAME OF PERSON MAKING STATEMENT)

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SIGNATURE OF NOTARY - STATE OF FLORIDA

☐ PERSONALLY KNOW ☐ PRODUCED IDENTIFICATION