



ZION LAND ACADEMY

APPLICATION FOR ENROLLMENT

Enrollment Date _____

NAME OF CHILD	
HOME ADDRESS	
DATE OF BIRTH	

MOTHER:	FATHER:
ADDRESS:	ADDRESS:
HOME PHONE:	HOME PHONE:
CELL PHONE:	CELL PHONE:

MOTHER'S WORK INFORMATION	FATHER'S WORK INFORMATION
EMPLOYER:	EMPLOYER:
ADDRESS:	ADDRESS:
Phone Number:	Phone Number:



Please advise us if there are any special needs or any special concerns for your child, such as asthma, allergies, or other existing illness.

EMERGENCY TREATMENT AUTHORIZATION

Child's Name: _____

Age: _____ Birth Date: _____

Address: _____

Parent's Name: _____

MEDICAL INFORMATION

Allergies: _____
(food allergies, asthma, etc.)

Medicines: _____

Child's Health Care Provider: _____

Telephone #: _____

Child's Insurance: _____

Identification #: _____ Group #: _____

I state that the information that has been provided is correct and I am the parent/legal guardian for the child listed above. You are hereby authorized to obtain emergency treatment for my child. I give my consent to an X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care for the minor at a recognized medical facility under the general or special supervision of a licensed physician or surgeon.

The following steps will be followed in the event of an emergency:

1. The parent/guardian will be notified immediately. However if life threatening emergency first aid will be contacted immediately.
2. The child's health care provider will be contacted
3. An attempt will be made to contact the parent/guardian through all of the emergency persons listed on the child's application form
4. If the parent/guardian or child's health care provider cannot be contacted we will do one or all of the following:
 - a. Call for emergency first aid assistance and transportation
 - b. Call another health care provider
 - c. Have the child transported to an emergency hospital in the company of a staff member

Parent Signature: _____

Date: _____

Staff Member Signature: _____ Date: _____

I attest to the following:

That the information provided is correct

That in the event of a medical emergency, I authorize Zion Land Academy to seek emergency medical care for my child as deemed necessary by the Director.

My child is in good health and is able to participate in the center's activities. My child has no medical conditions.

Parent Signature _____



ZION LAND ACADEMY
800-822 FLORA STREET
ELIZABETH, NEW JERSEY 07201
908-355-7210

EMERGENCY CONTACT/PICK UP INFORMATION
Person must be 18 years and older to pick up children

Please list person(s) that will be authorized to pick up your child(ren) or in case of emergency can be contacted if parents are unavailable. Proper Identification will be needed in order for your child to be released. If the name is not on the contact list the child will not be released unless the parent has called and provided the center with the name of the person picking up the child. ALL PERSONS MUST HAVE PHOTO IDENTIFICATION.

<u>CONTACT NAME</u>	<u>Relationship to Student</u>	<u>Phone Number – Home, Cell, Work</u>

If the information above changes during the school year, please notify the office and your child's teacher immediately.

Parent Signature_____

Date: _____