

# Jeffersonville Country Day School

1770 West Main Street Norristown, PA 19403 – Phone: 610.539.7499 – Fax: 610.672.9584 – www.jeffersonvillecds.com

## Registration Form

Please fill out this registration form completely. Accurate information is necessary so that we may best serve your child. It is your responsibility to notify us immediately of any changes in employment or residence. Thank you in advance for your cooperation.

### Child's Information

Child's Name (First) _____ (Middle Initial) _____ (Last) _____		Child's Nickname (if applicable) _____
Child's Present Address (No., Street) (City) (State) (Zip Code) _____		Child's Birthday _____
Child Lives With <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both <input type="checkbox"/> Other: _____		Enrollment <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary
Health Insurance Information (Provider Name) _____	(Policy Number) _____	(Name of Primary Policy Holder) _____
Primary Physician (Name) _____	(Address) - (No., Street) (City) (State) (Zip Code) _____	(Telephone Number) _____ ( _____ ) _____ - _____

### Primary Contact Information

First Name _____ Last Name _____	
Address (If different than child's address) (No., Street) (City) (State) (Zip Code) _____	
Relationship to Child <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other _____	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced/Remarried <input type="checkbox"/> Divorced/Single
Age _____	
Preferred Telephone Number ( _____ ) _____ - _____ <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Receives Text Messages	Email Address <input type="checkbox"/> Personal <input type="checkbox"/> Work
Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Self Employed <input type="checkbox"/> Homemaker <input type="checkbox"/> Retired <input type="checkbox"/> Other _____	Employer/Company Name _____ Job Title _____
Employer Address (No., Street) (City) (State) (Zip Code) _____	
Employer Telephone Number ( _____ ) _____ - _____	Contact Authorized to Pick-Up Child? <input type="checkbox"/> Yes <input type="checkbox"/> No

### Secondary Contact Information

First Name _____ Last Name _____	
Address (If different than child's address) (No., Street) (City) (State) (Zip Code) _____	
Relationship to Child <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other _____	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced/Remarried <input type="checkbox"/> Divorced/Single
Age _____	
Preferred Telephone Number ( _____ ) _____ - _____ <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Receives Text Messages	Email Address <input type="checkbox"/> Personal <input type="checkbox"/> Work
Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Self Employed <input type="checkbox"/> Homemaker <input type="checkbox"/> Retired <input type="checkbox"/> Other _____	Employer/Company Name _____ Job Title _____
Employer Address (No., Street) (City) (State) (Zip Code) _____	
Employer Telephone Number ( _____ ) _____ - _____	Contact Authorized to Pick-Up Child? <input type="checkbox"/> Yes <input type="checkbox"/> No

### Emergency Contacts (Other than Contacts Above)

Please list additional emergency contacts you authorize us to contact in the event of an emergency if we are unable to contact the primary or secondary contacts named above.

Name _____	Telephone Number ( _____ ) _____ - _____	Relationship _____
Address (No., Street) (City) (State) (Zip Code) _____		
Name _____	Telephone Number ( _____ ) _____ - _____	Relationship _____
Address (No., Street) (City) (State) (Zip Code) _____		
Name _____	Telephone Number ( _____ ) _____ - _____	Relationship _____
Address (No., Street) (City) (State) (Zip Code) _____		

### Additional People Authorized to Pick-Up Child

The above-named child will not be permitted to leave the program with anyone who is not listed below. Authorized individuals must pick up the child in person and may be requested to show identification to Jeffersonville Country Day School staff. †

Name _____	Telephone Number ( _____ ) _____ - _____	Relationship _____
Name _____	Telephone Number ( _____ ) _____ - _____	Relationship _____
Name _____	Telephone Number ( _____ ) _____ - _____	Relationship _____

† Children will not be released to persons who fail to provide acceptable identification upon request.

\*\* There is a non-refundable registration fee of \$50.00.

\*\* Parents will be required to obtain an age-appropriate health assessment form (form attached), certified by a licensed physician. This form is due no later than your child's first day of school. Your child cannot begin school without the health assessment form.

\*\* See tuition contract for infant registration fees.