

BIBLE BAPTIST CHRISTIAN SCHOOL

A Ministry of Bible Baptist Church

2780 Mount Carmel Road Hampton Georgia 30228

Phone: 770.946.4708 Fax: 770.946.4715

Before & After Care Permission Form

STUDENT'S NAME: _____ GRADE: _____

ADDRESS: _____ HOME PHONE: _____

CITY/STATE/ZIP: _____

FATHER: _____ WORK NUMBER: _____

CELL NUMBER: _____

MOTHER: _____ WORK NUMBER: _____

CELL NUMBER: _____

PERSON(S) AUTHORIZED TO PICK-UP STUDENT {other than parents}:

NAME/RELATIONSHIP: _____ PHONE NUMBER: _____

NAME/RELATIONSHIP: _____ PHONE NUMBER: _____

NAME/RELATIONSHIP: _____ PHONE NUMBER: _____

NAME/RELATIONSHIP: _____ PHONE NUMBER: _____

IN CASE OF AN EMERGENCY CALL {other than the numbers listed above}:

NAME/RELATIONSHIP: _____ PHONE NUMBER: _____

NAME/RELATIONSHIP: _____ PHONE NUMBER: _____

LIST APPROXIMATE DAYS/HOURS A WEEK YOU WILL BE USING THESE SERVICES:

DAYS: _____

HOURS: _____

ANY MEDICAL HISTORY WE MAY NEED TO KNOW TO BETTER CARE FOR YOUR CHILD
{allergies, etc.} _____

CHILD'S BIRTHDAY: _____ WEIGHT: _____

DATE OF LAST TETANUS INJECTION: _____

CHILD'S PHYSICIAN {name, address & phone number}: _____

I UNDERSTAND THAT ALL POSSIBLE MEASURES WILL BE TAKEN TO INSURE MAY CHILD'S SAFETY. IN CASE OF AN EMERGENCY, I GIVE PERMISSION TO THE ADULT IN CHARGE, TO ACT ON MY BEHALF IN OBTAINING MEDICAL AID. IF AN EMERGENCY SHOULD ARISE, YOUR CHILD WILL BE TAKEN DIRECTLY TO HENRY GENERAL MEDICAL CENTER IN STOCKBRIDGE.

PARENT'S SIGNATURE

DATE