



SUNLIGHT

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802-479-0141

Kids' Club

# Registration Form

## Child Information:

Child's Full Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Language: \_\_\_\_\_

## Parent/Guardian Information:

Parent/ Guardian Full Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Parent/ Guardian Address (If Different): \_\_\_\_\_

Email Address: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Parent/ Guardian Full Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Parent/ Guardian Address (If Different): \_\_\_\_\_

Email Address: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Court Order In Effect For: \_\_\_\_\_

## Authorized Pick Up:

List all individuals who are authorized to pick up your child:

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

## Emergency Contacts:

If neither parent/guardian can be reached in case of emergency, call:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

## Medical Contacts:

Name of Child's Doctor \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Child's Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Child's Well-Care Exam Documentation  Child's Immunization Record

## Additional Information:

Please describe any additional information you would like us to know about your child. This could include special medical, developmental, emotional or educational needs, allergies, existing illness or injuries, previous serious illnesses or injuries and any prescribed medication including those for emergency situations. Please use space on back and sign!

# Additional Information:

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Child's Educational Documentation (E.G. IEP, CIS One Plan, or equivalent)

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Parent/Guardian Signature

Date

SONLIGHT KIDS' CLUB					
SUMMER 2023					
RESERVATION					
	WEEK:	CHILD 1 NAME:	CHILD 2 NAME:	CHILD 3 NAME:	CHILD 4 NAME:
	JUNE 5TH - JUNE 9TH				
	JUNE 12TH - JUNE 16TH				
	JUNE 20TH - JUNE 23RD				
	JUNE 26TH - JUNE 30TH				
	JULY 3RD - JULY 7TH	CLOSED	CLOSED	CLOSED	CLOSED
	JULY 10TH - JULY 14TH				
	JULY 17TH - JULY 21ST				
	JULY 24TH - JULY 28TH				
	JULY 31ST - AUGUST 4TH				
	AUGUST 7TH - AUGUST 11TH				
	AUGUST 14TH - AUGUST 18TH				
	AUGUST 21ST - AUGUST 25TH				
FAMILY NAME: _____					
CONTACT PHONE: _____					
CONTACT EMAIL: _____					

# EMERGENCY CONTACT LIST

CHILD'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

PLEASE FILL OUT AND SIGN A NEW EMERGENCY CONTACT LIST EACH YEAR

MY NAME: \_\_\_\_\_

PLEASE PRINT FULL NAME



CHILD'S DOCTOR'S INFORMATION:

HOME: \_\_\_\_\_

NAME: \_\_\_\_\_

MOBILE: \_\_\_\_\_

TEL: \_\_\_\_\_

WORK: \_\_\_\_\_



MY CHILD IS CURRENTLY TAKING  
THESE MEDICATIONS:

\*NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

\*NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

**ALLERGIES:**

POTENTIALLY LIFE  
THREATENING? YES NO

Parent / Guardian Signature: \_\_\_\_\_

**EMERGENCY  
DIAL 911**

# LFN/WCA/SONLIGHT Medication/Medical Authorization

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## Medical Contacts:

Student's Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Student's Dentist: \_\_\_\_\_ Phone #: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_ Phone #: \_\_\_\_\_

## Medications:

I/We give permission for Little Flock Nursery staff to give our child the following (please check individually)

- |   |                                |                          |
|---|--------------------------------|--------------------------|
| <input type="checkbox"/> Sunscreen        | Triple Antibiotic Ointment     | <input type="checkbox"/> |
| <input type="checkbox"/> Insect Repellant | Hydrocortisone/Anti-Itch Cream | <input type="checkbox"/> |
| <input type="checkbox"/> Diaper Cream     | Tylenol                        | <input type="checkbox"/> |
| <input type="checkbox"/> Benadryl         | Ibuprofen                      | <input type="checkbox"/> |

## Authorization:

I/We, as parents/guardians, take full responsibility for any side effects that may be caused by the medications we are authorizing to be administered. We understand that Little Flock Nursery is only administering the medication at our request and will not be held responsible for any adverse reactions.

I/We agree to allow the staff of LFN/WCA to seek emergency care for our child as needed.

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

SONLIGHT: 317 Vine St, Barre, VT 05641 P:802-622-0298  
143 CHURCH HILL ROAD, WEBSTERVILLE VT 05678 · P: (802) 479-0141 · F: (802) 476-7834 ·  
WCAVT.ORG · LFN@WCAVT.ORG

## *CDD Licensing Permission and Understanding Statements:*

\_\_\_\_\_ I understand that every effort will be made to contact me in case of an emergency. If I'm not able to be reached during a medical emergency, I hereby authorize WCA, Little Flock Nursery and Preschool, or Sonlight Kids' staff to obtain emergency medical care for my child(ren):

\_\_\_\_\_ (child's name)

\_\_\_\_\_ (child's name)

\_\_\_\_\_ (child's name)

\_\_\_\_\_ (child's name)

\_\_\_\_\_ (child's name)

\_\_\_\_\_ In addition, if my child requires emergency medical transportation, I authorize my child to be transported.

\_\_\_\_\_ I acknowledge that I am aware that religious activities will be offered in this program.

\_\_\_\_\_ I acknowledge that no tobacco products are permitted on WBC premises.

\_\_\_\_\_ I authorize my child/ren to participate in walking trips.

\_\_\_\_\_ I authorize my child/ren to participate in wading pool or sprinkler activities.

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

LFN/ SONLIGHT Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## *Sunlight Kids' Club*

What to bring to camp?

- Backpack
- 3 - Changes of Clothes
- Swim Gear for Water Games
- Bug Protection
- Sun Protection
- Toiletries
- Water Bottle
- Lunch and Snacks
- Books to Read
- Appropriate Shoes for the Outdoors

**ATTENTION**

Please label all  
of your child's  
belongings!  
Thank you!

