

**SMBC Parents Day Out**  
**3515 Grandview Avenue, Louisville, KY 40207**  
**Telephone # 896-8882 Fax # 896-0439**  
**Director, Missey McMillan**

Child's Name \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Date of Birth (MM/DD/YY) \_\_\_\_\_ Sex \_\_\_\_\_

Mother's Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mother's Place of Employment \_\_\_\_\_

Father's Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father's Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Father's Place of Employment \_\_\_\_\_

E-mail \_\_\_\_\_

Siblings (Names and Ages) \_\_\_\_\_

Name of Church Child Attends \_\_\_\_\_

**\*\*\*PLEASE FILL OUT THE BACK SIDE AS WELL!!!\*\*\***

**Office Use:**

Tues. \_\_\_\_\_ Thurs. \_\_\_\_\_

Months by Oct. 1 \_\_\_\_\_

Pd. Registration \_\_\_\_\_

## **MEDICAL INFORMATION**

Emergency names and phone numbers (please list two different from parents)

Name	Phone	Relationship
1.	_____	_____
2.	_____	_____

Doctor's Name \_\_\_\_\_ Doctor's Phone \_\_\_\_\_

Allergies \_\_\_\_\_

Other Medical Information \_\_\_\_\_

\_\_\_\_\_

I hereby give my permission for medical treatment by a doctor in case of an Emergency:

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Insurance and Policy Number