

2714 W. Maryland St. Bellingham, WA 98225 / 393.6310
www.themadronaschool.com



REGISTRATION INFORMATION

Child's Name:	Birthdate: Current age: Gender: M F
Parent/Guardian Name(s): (1) (2) ADDRESS (1): _____ _____ ADDRESS (2): _____ _____	Telephone Numbers: HOME: WORK: WORK: CELL: CELL: EMAIL (1): _____ EMAIL (2): _____
Emergency Contact 1: Relationship:	Emergency (1) Telephone Numbers: HOME: WORK: CELL:
Emergency Contact 2: Relationship:	Emergency (2) Telephone Numbers: HOME: WORK: CELL:
Doctor/Clinic: Telephone: Date of last exam:	Any Allergies and Health History:

Registration Form



Child's Name:	Birthdate:	Current age:
	Gender: M F	
Insurance Coverage: yes no	Parent Signature:	
Name of Company:	Date: _____	
Policy Number:	Updated: _____	

REGISTRATION FEE: \$110.00 annual supply and registration fee

THE FEE IS DUE AT TIME OF REGISTRATION TO CONFIRM YOUR CHILD'S SPACE.

PLEASE MAKE CHECKS PAYABLE TO: THE MADRONA SCHOOL

PARENT CONSENT FORMS: Please read and sign the consent items on the following page to complete your registration.

THANK YOU!!!!

Parent Consent Items	Parent Signature	Date
1. Photos of your child may be taken to share projects with families and in school documentation. Photos may also be used in a future brochure, flyer or website. (No name is attached to a picture used in advertising).	Consent to photograph your child: YES NO Signature: _____	
2. Consent to visit the fenced in garden area on the west side to the school building.	YES NO Signature: _____	
3. Consent for neighborhood walks and walks to surrounding parks of Squalicum Fields and Birchwood Park.	YES NO Signature: _____	

MEDICAL AUTHORIZATION AND CONSENT

I, _____ (parent or legal guardian) hereby give permission that my child, _____, may be given emergency treatment to include first aid and CPR by a qualified child care staff member at The Madrona School.

I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by my child's regular physician, or when the physician can not be reached, by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health and I cannot be contacted. I waive my right of informed consent to such treatment.

I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____