



DEL SOL SCHOOL REGISTRATION RENEWAL

INSTRUCTIONS: Please complete and return this form to Del Sol School. Feel free to put this form in a sealed envelope to ensure confidentiality. If you have any questions regarding this form, please feel free to contact Del Sol School at (714) 828-6409.

Child's Name: _____ Date: _____
(Last) (First) (Nickname)

Sex: _____ Date of Birth: _____ Age: _____ School Year: _____

Parent: _____
(Last) (First) (Middle)
Present Address: _____
(Street) (City and Zip) (County)
Phone: _____ Cell Phone: _____

Parent: _____
(Last) (First) (Middle)
Present Address: _____
(Street) (City and Zip) (County)
Phone: _____ Cell Phone: _____

Legal Custody: Joint Mother Father Other

CONSENT FOR PHOTOGRAPHS AND VIDEOTAPING:

INSTRUCTIONS TO PARENTS: The following authorization permits Del Sol School to take photographs of and video tape your child. Tapes are used to track student progress. Tapes will not be used for marketing or commercial purposes. Tapes will not be used outside Del Sol School without prior consent. Del Sol School may use photos for program displays or presentations.

I, _____ give my consent to allow _____ to be
(parent's name) (child's name)
photographed by Del Sol School.

I, _____ give my consent to allow _____ to be videotaped
(parent's name) (child's name)
by Del Sol School.

EMERGENCY CONTACTS:

INSTRUCTIONS TO PARENTS: The following authorization permits Del Sol School to release your child to the following responsible adults in case of an emergency.

I, _____ give my consent to allow _____ to be released
(parent's name) (child's name)
to the following responsible adults:

Emergency Contacts			
Name	Relationship	Phone #1	Phone #2
1			
2			
3			
4			
5			

Signed: _____ Date: _____

HEALTH CARE INFORMATION:
INSTRUCTIONS TO PARENTS: *The following authorization permits Del Sol School to obtain medical assistance for your child in case of an emergency.*

Child's Name _____ Date _____

PERMISSION FOR HEALTH CARE

In the event of an emergency during which I cannot be reached, the physician listed in this packet and the local hospital are authorized to provide any emergency care deemed necessary for my child.

Signed: _____ Date: _____

FIRST AID

In the event of an emergency I authorize Del Sol School staff to provide any first aid deemed necessary.

Signed: _____ Date: _____

MEDICAL INFORMATION	
Child's Physician:	
Address:	Phone #
Child's Dentist:	
Address:	Phone #

Signed: _____ Date: _____