Bread of Life
Christian Bilingual Preschool

西雅圖靈糧堂雙語幼兒園
preschool@seabol.org
425-451-7477

Applying for the school year 20____ to 20____
Current BOLCBP family? ☐ Yes ☐ No
Past BOLCBP family? ☐ Yes ☐ No

Enrollment Form

Student Information **Date:**

First, Middle, Last Name	Date of Birth	Age	Gender
Street Address	City	Postal Code	
Additional Address (in instances child resides with more than one parent)			

Class Selection ☐ Preschool(2.5-4 year old) ☐ Pre-K(4-5 year old)

☐ Half Day (9:00am-12:30pm) 5 Days

☐ Full Day (9:00am-3:30pm)
- ☐ 5 Days
- ☐ 3 Days(M,W,F)

☐ Afterschool (3:30am-6:00pm)
- ☐ 5 Days
- ☐ 3 Days(M,W,F)
- ☐ 2 Days (T,Th)

Parent Information

Parent Name	Relation to child	Work Phone	Cell Phone	Email

(If parents are separated or divorced, with whom does the child reside? _____)

Emergency Contact Information
(In case when parents cannot be reached.)

Name(s)	Relationship	Phone Number	Alt. Phone Number	Authorized to Pick Up Child
				☐ Yes ☐ No
				☐ Yes ☐ No

Child Health Information

Date of child's last physical exam:	Child's healthcare provider:	Provider telephone number:
Street address	City	Zip Code
Any allergies/health problems? ☐ Yes ☐ No *If yes to either, please fill out separate Allergy/Medication Forms.*	Any medications? ☐ Yes ☐ No	
List all allergies & mark level of severity: ☐ Mild ☐ Severe ☐ Life-threatening	List all health problems & mark level of severity: ☐ Mild ☐ Severe ☐ Life-threatening	
Child's dentist name:	Dentist telephone number:	
Street address	City	Zip Code

Child Medical Insurance Coverage

Insurance company name:	Member/policy number:
Policy holder name:	Employer name:

Consent to medical care and treatment of minor children

I give permission that my child, _____, may be given

emergency treatment by a qualified child care provider at _____,

When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health. I waive my right of informed consent to such treatment.

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

I certify under penalty of perjury under the laws of State of Washington that this information is true and correct.

Parent/guardian signature_____ Date_____

Parent/guardian signature_____ Date_____