

South Shore Children's Center of West Islip, Inc. 350 Higbie Lane West Islip, NY 11795 631-376-1234 FAX 631-376-1313 WWW.SSCLC.COM



Registration, Identification & Emergency Information

Child's Name:			<u>M / F</u>
Date of Birth:Ses	sion Code:		
Address:			
City:			
Does your child have any known	allergies?		
Treatment:			
Parent #1/Guardian Name:			
Telephone#	Cell/Bee	:per#	
Employment	Pho	one #	
Parent #2/Guardian Name:			
Telephone#	Cell/Bee	:per#	
Employment	Phor	ne #	
Child's Physician:	Phone#	<i>‡</i>	
Emergency Hospital Preference			
Email Address			



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Authorized Pick-Up/Emergency Closing Record

Child's name:		Session:			
To ensure the safety of your child/children we will under no circumstance release your child/children to any person(s) not listed below without prior authorization from the parent/guardian. NO EXCEPTIONS.					
•	ons authorized to pick up your chil well as their address and preferr	d/children after school or in the event ed phone number.			
Parent 1	Address	Phone #			
Parent 2	Address	Phone#			
Name/Relationship	Address	Phone#			
Name/Relationship	Address	Phone #			
Name/Relationship	Address	Phone #			
Name/Relationship	Address	Phone#			
All authorized pick up pers	ons will need to submit a photo I.[). the first time they pick up your			

child/children. A copy will be retained in the child's file for future use. If possible, please notify your pick up person of this policy prior to pick up. No child will be released to anyone who cannot provide I.D.

*If at all possible, please submit copies of the photo ID of those authorized to pick up prior to the beginning of school.

P	lease	sign	bel	low



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Authorization for Automatic Tuition Payments by Credit/Debit Card

If you would like the option of having your tuition charges automatically charged to either your MasterCard or Visa, please fill out the bottom portion of this form and return it by June 1 st .		
Charges will be made according to the regular payment schedule on the first of the month they are due.		
I, (Please print)		
hereby authorize South Shore Children's Center to charge my monthly tuitions		
payments as they are due, for my child/children:		
to the following credit/debit card: MASTERCARD VISA		
ACCOUNT NUMBER:		
NAME (As it appears on the credit card)		
EXPIRATION DATE:		
AMOUNT TO BE CHARGED EACH MONTH:		

SIGNATURE OF CARDHOLDER:



Parent/Guardian Signature___

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Medical Release

In the event a child requires medical attention, the following steps will be taken by the Director or Acting Director to obtain necessary medical care. These steps include, but are not limited to:

- Contact Emergency Services via 911
- Attempt to contact parent(s)/guardians(s)
- Attempt to contact child's physician
- Attempt to contact parents(s)/guardians via the emergency contact person(s)

Any expenses incurred in obtaining medical attention for a child will be the responsibility of the parents(s)/guardian(s).

I understand the information given above, and therefore give permission for my child/children to receive emergency medical attention if necessary.

Photo Release
(sign one or the other)
I do give permission for my child's photo to be used on our Facebook page

2 do give permission for my er	mas photo to be used on our racebook page.
Parent/Guardian signature	_
I do not give permission for mour Facebook age.	ny child's photo to be used on our Facebook page.
Parent/Guardian signature	_