

JETS CLUB REGISTRATION

Child's Name: _____

Address: _____

Phone: _____ Age: _____ D.O.B. _____

Grade 2010-2011 _____

Mother's Name: _____ Work Phone _____

Father's Name: _____ Work Phone _____

Please circle your choice of care.

Before School

After School

Both

Please circle the days you require care for your child

Monday

Tuesday

Wednesday

Thursday

Friday

Persons to contact in case of an emergency:

1.) Name: _____

Address _____ Phone: _____

Persons to whom child may be released:

1.) _____ 2.) _____

3.) _____ 4.) _____

Registration fee of \$10 per child is due before the registration can be processed.

**CHILD INFORMATION RECORD
STATE OF MICHIGAN
Department of Human Services
Bureau of Children and Adult Licensing**

Date of Admission		Allergies					
Date of Discharge							
Name of Child (Last, First, Middle Initial)				Address (Number and Street, Building/Apartment Number)			
Child's Date of Birth		Home Phone ()		City		State	Zip Code
Father/Legal Guardian's Name		Home Phone		Mother/Legal Guardian's Name		Home Phone	
Home Address (if not child's address)		Cell Phone		Home Address (if not child's address)		Cell Phone	
City	State	Zip Code		City	State	Zip Code	
Employer/School Name				Employer/School Name			
Address (Employer/School)				Address (Employer/School)			
City		State	Zip Code		City	State	Zip Code
Employer/School Phone		Daily Work/School Times		Employer/School Phone ()		Daily Work/School Times	
Name(s) of Person other than Parent or Legal Guardian to whom child may be released							

BCAL-3731 (Rev. 9-09) Previous editions 3-08, 10-07, & 1-06 may be used.

See Reverse Side

I give permission to _____, licensed by the Department of Human Services
(Provider's Name)

to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.

Signature of Parent or Guardian		Date Signed	
Name of Child's Physician or Health Clinic		Physician's or Health Clinic's Phone Number ()	
Address of Child's Physician or Health Clinic		Name of Health Insurance Carrier	
Hospital Preferred for Emergency Treatment		Health Insurance Policy Number	
Special Needs:		Date of Last D'TaP (Diphtheria, tetanus, pertussis) Shot	
Name of Local Person to be Notified in an Emergency When Parents Not Available		Local Address of Emergency Person	
Home and/or Cell Phone ()	Work Number ()	City, State	Zip code
Special Instructions:			
Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.			AUTHORITY: 1973 PA 116 COMPLETION: Required PENALTY: Rule Violation Citation.

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