TheSpringsKids

Parent/Guardian_____

Cell Phone_____ Email _____

Address _____

City_____State_____Zip_____

I give permission to the following to pick up my child. Must be 16yrs+

Name _____ Cell _____

Name _____ Cell _____

Information below is for children attending service at Holly Springs

Child's Name/Nickname _____ Last _____

Birthday _____/_____/_____ M F Age _____ School _____

My Child Has The Following Allergies:
Eggs ____ Milk _____ Peanuts _____ Tree nuts _____ Fish _____ Shellfish _____ Wheat _____
Soy _____ Red Dye _____ Blue Dye _____ Other _____
My Child Does Not Have Any Known Allergies: _____

My Child Has The Following Special Needs:
ASD ____ ADD/ADHD ____ CF____ CP____ DB _____ DS _____ FAS _____ MD_____ SB _____
Other_____

My Child Has Trouble With The Following Sensory:
Flashing Lights _____ Sounds _____ Smells _____ Oral _____ Touch _____

I Give Permission For My Child To Play Outside Y_____ N _____

My Child Will Be In The Following Age Group:

Rain Drops (PreK) _____ Puddles (K & 1st) _____ Splashes (2nd & 3rd)_____
Waves (4th & 5th) _____Tsunamis (Middle School)_____ Natural Disaster (HighSchool)_____

I understand that no medication will be given to my child by any one other than a parent/guardian while in the care of Holly Springs Baptist Church. I also understand that no one may pick up my child other than whose names have been given.
All information provided is correct according to the best of my knowledge.

Signature_____