



Unit #: _____
 School Year: _____

THE CHILDREN'S CENTER AT U.C.P.
9 Smiths Lane, Commack, New York 11725
(631) 543-2338 FAX: (631) 543-5981

REGISTRATION FORM

(Please Print)

STUDENT NAME: _____ DATE COMPLETED: _____
 ADDRESS: _____ DATE OF BIRTH: _____
 _____ School District: _____
 PARENT/GUARDIAN: _____
 HOME PHONE #: _____ If foster child, please note your:
 Name: _____
 BUSINESS PHONE #: _____ Foster Care Agency: _____
 Address: _____
 CELL #: _____ Phone #: _____
 Case Worker: _____



ETHNICITY:

African American	<input type="checkbox"/>	Asian	<input type="checkbox"/>
American Indian/Alaskan Native	<input type="checkbox"/>	Hispanic or Latino	<input type="checkbox"/>
Multiracial	<input type="checkbox"/>	Native Hawaiian/Pacific Islander	<input type="checkbox"/>
White	<input type="checkbox"/>		



EMERGENCY CONTACTS:

In case of an **Emergency**, I give permission for The Children's Center to obtain medical emergency services for my child.
 YES NO

In case of an **Emergency**, my child may be released to any of the following people:

Name: _____ Phone #: _____
 Name: _____ Phone #: _____

 Signature of Parent/Guardian

 Date

TO BE RETURNED TO MAIN OFFICE