

**PRESCHOOL DROP-IN CARE FORM**

City Christian Schools  
 9200 NE Fremont St., Portland, OR 97220  
 (503) 252-5207 FAX: (503) 257-2221

Office Use:
Date Rec'd: _____
CCP Admin Approved: _____
Parent Contacted: _____
Fee Paid: _____

Date: \_\_\_\_\_

Child's Name \_\_\_\_\_  
 (First) (Middle) (Last)

Telephone (\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

**Campus:**

Rocky Butte       Mill Plain       217

**If you are interested in drop-in care the following conditions must be met:**

1. Current enrollment into preschool program or CCS Kindergarten
2. Availability of space in the classroom
3. At least 24 hours of advanced notice given to the campus supervisor (or arranged Friday for a Monday change)
4. Drop-in care form completed
5. Cash or check payment made BEFORE drop-in care is given according to the following payment schedule:

Half Day	Full Day	AM Extended Care	PM Extended Care
8:45-11:30 OR 11:30-3:00	8:45-3:00	7:30-8:45	3:00-6:00
\$25	\$40	\$10	\$20

**Drop-In Schedule Requested (write dates in appropriate boxes):**

	Monday	Tuesday	Wednesday	Thursday	Friday
Half Day					
Full Day					
AM Extended Care					
PM Extended Care					

\_\_\_\_\_  
 (Signature of Parent or Guardian)

\_\_\_\_\_  
 (Date)

**CCS Kindergarten: Please see reverse side to fill out emergency contact information**

**EMERGENCY INFO FORM**  
**CITY CHRISTIAN PRESCHOOL**  
complete all blanks in blue or black ink. If none, indicate "none."

Student's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
*(Last) (First) (Middle)*

Age \_\_\_\_\_ Gender \_\_\_\_\_

Address \_\_\_\_\_  
*(Street) (City) (State) (Zip)*

Parent's Name \_\_\_\_\_

Home Phone # (\_\_\_\_\_) \_\_\_\_\_

Father's Work # (\_\_\_\_\_) \_\_\_\_\_ Mother's Work # (\_\_\_\_\_) \_\_\_\_\_

Father's cell ph. # (\_\_\_\_\_) \_\_\_\_\_ Mother's cell ph.# (\_\_\_\_\_) \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

Name of Medical Insurance Co. \_\_\_\_\_ Group or I.D. # \_\_\_\_\_

**Local Family/Friend who should be contacted in an emergency situation when parents cannot be reached:**

Name \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

Relationship \_\_\_\_\_

**Name of person who will be dropping off and picking up your student:**

Drop off: \_\_\_\_\_

Pick up: \_\_\_\_\_

**Comments:**

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**Please read and check appropriate boxes below regarding off-campus activities.**

Yes  No  In the event of an emergency I authorize CCS staff to obtain medical treatment for my child and allow them to be transported to Portland Adventist Hospital (Rocky Butte)

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_