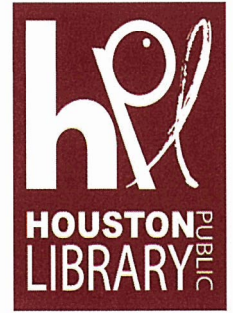


**HOUSTON PUBLIC LIBRARY  
City of Houston Employees  
Enrollment Information**



City Department:	ID#:
Email Address:	

**ENROLLMENT INFORMATION (FOR CHILD)**

Last Name	First Name	MI
Current Address:		Apt #
City / State:	Zip Code:	Home Phone: ( ) Cell Phone: ( )
Email Address:		
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age:

**PARENT/ GUARDIAN**

Name:	Relation:
Address:	Home Phone: ( )
Work Phone: ( )	Cell Phone: ( )

**EMERGENCY CONTACT (Other than Parent/Guardian)**

Name:	Relation:
Address:	Home Phone: ( )
Work Phone: ( )	Cell Phone: ( )

Signature of parent or guardian:	Date:
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Printed Name:

**MEDIA RELEASE AGREEMENT:**

It is my understanding that if my child is photographed/video taped, portions of it may be used for public view. I agree to participate or to have my child participate in this without financial remuneration, and I understand that signing this document releases the Houston Public Library/ photographer/videographer/ interviewer from any future claims, as well as from any liability arising from the use of said photograph/ video tape/ interview.

(place your initials next to one of these options)    I Agree \_\_\_\_\_    I Decline \_\_\_\_\_\*

\*If I wish for HPL or any authorized person to NOT take a photographic and/ or audio image of my child(ren), I understand that HPL staff will make all reasonable efforts to respect my wishes; however, I understand that HPL cannot guarantee that photographic and/or audio images will not be taken by HPL staff or any authorized or unauthorized person and I will hold HPL harmless for the actions of any or all persons who take or attempt to take photographic and/or audio images of my and/or my child/children. I understand that there is no payment or compensation for the use of any images taken.  
( initial here if permission is declined\* )

**MEDICAL INFORMATION - IN CASE OF EMERGENCY**

List any known allergies, including food and drug allergies:

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List any medication prescribed for long term, continuous use:

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List any special problems your child may have including previous or existing illness or injuries:

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Other information that staff should be made aware of:

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Date of last Tetanus Booster: (if known) \_\_\_\_\_

**EMERGENCY MEDICAL CARE**

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility to take my child to: \_\_\_\_\_

Name of Physician:

Address:

Phone: ( )

Name of Hospital or Clinic:

Address:

Phone: ( )

**I understand that if my child becomes ill or poses a discipline problem, I will be contacted and required to remove my child from the library's care. Please initial that you have read and agreed to the above ( )**

Signature of parent or guardian:

Date:

Printed Name: