



NXT KIDS VISITOR CHECK-IN

INFANTS THROUGH GRADE 5

Parent(s) First and Last Name _____

Parent Date of Birth (MM/DD/YYYY) _____

Your Name (if not the parent) _____ Relationship to Child _____

Child's School _____

Child's Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____

Email _____

Where will you be during service? _____

Child's Information

Child's Full Name	Date of Birth	Age	Grade	Gender	Allergies/Medical Conditions

Parents or a responsible party are required to remain on the premises while your children are here. If in the event an emergency arises and you are not available, your signature below will give us permission to authorize medical treatment.

Parent's Signature _____ Date _____