Date Received: _____

Calvin Christian School
Shadow Day Form

Please complete and return to the school office five days before requested Shadow Day.

Requested Shadow Date: _____

Child's Name: _____ Date of Birth: _____

Current School: _____ Current Grade: _____

Parent(s) Name(s): _____

Address: _____

Home Number: _____ Cell Number: _____

Work Number: _____ Email Address: _____

Emergency Contact Name: _____ Phone Number: _____

To Note (Medical/Otherwise): _____

_____

_____

By signing below, I give permission for my child, _____
to attend Calvin Christian School on _____.

_____ _____

Parent Signature **Date**

My child is a friend of: _____

I am interested in:

_____ receiving a tour of the school
_____ talking to a current CCS parent about their experience
_____ hearing about other special events

Faith. Learning. For *life*.