Pre-Registration Form 2020-2021
Mother's Day Out School Program

A Weekday Preschool Ministry of
First Baptist Church
508 Second Street
Natchitoches, LA 71457

Date: _____

Child's Full Name: _____
First Middle Last

Name to be called: _____

Sex____ Age ____ Birthdate: _____ Potty Trained? _____

Parents:

Mother's Name: _____

Home Address: _____
Street or P.O. Box City State Zip

Phone: Home _____ Work _____ Cell _____

Occupation: _____ Employer: _____

Father's Name: _____

Home Address: _____
Street or P.O. Box City State Zip

Phone: Home _____ Work _____ Cell _____

Occupation: _____ Employer: _____

Parent's Marital Status: Married _____ Separated _____ Divorced _____

Does the child live with both parents? _____

If not, with whom does the child live? _____

Who is the person responsible for tuition? _____

Mailing Address: _____
Street or P.O. Box City State Zip

Phone: Day _____ Evening _____

Does your family attend a local church? ___ Yes ___ No

If so, where? _____

Siblings (name and age):

_____ _____

_____ _____

Medical Information

Does your child have any allergies or medical concerns? _____

If yes, please explain: _____

_____

_____

Emergency Contact Information:

(1) _____ Phone _____

(2) _____ Phone _____

Release of Child:

I authorize that my child, _____, be released by First Baptist Church WEE School Program to the following persons, in addition to those already listed on this form:

Name: _____ Relationship to child: _____

Home Address: _____
Street or P.O. Box City State Zip

Phone: Home _____ Work _____ Cell _____

Name: _____ Relationship to child: _____

Home Address: _____
Street or P.O. Box City State Zip

Phone: Home _____ Work _____ Cell _____

Emergency Medical Care

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize First Baptist Church WEE School Program staff to take my child to an Emergency Room, or to the following physician and/or his/her associates, for medical care.

Dr. _____ Hospital: _____

Address: _____
City State Zip

Phone: _____

Special Instructions: _____

_____

(Attach a photocopy of your medical insurance card and child's immunization record.)

I give consent for any and all treatment deemed necessary by the attending physician.

_____
Signature of Parent/Guardian

State of Louisiana

Parish of _____

Sworn to and subscribed before me on this _____ day of _____ 2020.

_____
Notary Public