First Baptist Church Weekday Child Enrollment Form

(Please fill in enrollment form completely and legibly)

Child's Full Name: _____ Date of Birth: _____

Preferred Name: _____ Gender: ☐ Male ☐ Female

Child's Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Date of Enrollment: _____

Parent/Guardian Information (The enrolling Parent/Guardian listed first will be the first contact in the event of illness/other concerns)

Enrolling Parent/Guardian: _____
(Last Name) (First Name) (Middle Initial)

Relationship to the child: _____ Home Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ Occupation: _____

Please note the phone number you would like notified first in the case of emergency/other concerns.
☐ Work Phone #: _____ Ext: _____ Work Hours: _____
☐ Cell Phone #: _____ ☐ Other Phone #: _____
E-mail Address: _____ Driver's License #: _____

Other Parent/Guardian: _____
(Last Name) (First Name) (Middle Initial)

Relationship to the child: _____ Home Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ Occupation: _____

Please note the phone number you would like notified first in the case of emergency/other concerns.
☐ Work Phone #: _____ Ext: _____ Work Hours: _____
☐ Cell Phone #: _____ ☐ Other Phone #: _____
E-mail Address: _____ Driver's License #: _____

Child's Primary Residence: ☐ with Both Parents ☐ with Mother ☐ with Father
☐ with Guardian (Name): _____
Siblings living at home: _____, _____, _____

Parent's Marital Status: ☐ Married ☐ Single ☐ Divorced
If divorced, custodial parent? _____
May the non-custodial parent pick up the child? ☐ Yes ☐ No *If no, court documentation is required

Family Religious Preference: _____ Church Membership: _____

I have read and completed all information on page 1 of the FBC~CW enrollment form to the best of my knowledge.

_____ _____
Parent/Guardian Signature **Date**

Enrollment Form, Continued

(Please fill in enrollment form completely and legibly)

Emergency Contact

List a local person who will be available to assume responsibility for your child in an emergency if parent/guardian cannot be reached.

Name: _____ Relationship to child: _____
Address: _____ City: _____ State: _____ Zip: _____
Driver's License #: _____
Phone # (where person can be reached during FBC~CW operational hours): _____

Emergency Medical Care

In the event I cannot be reached to make arrangements for emergency medical attention, I authorize the FBC~CW staff to take my child to an emergency room, or to the following physicians or his/her associates, for medical care.

Dr: _____ Clinic: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Hospital: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

I give consent for FBC~CW to secure any and all necessary emergency medical care for my child.

_____
Parent/Guardian Signature

Authorized Pick-Up/Release

Name: _____ Relationship to Child: _____
Driver's License #: _____
Phone # (where person can be reached during FBC~CW operational hours: _____

Name: _____ Relationship to Child: _____
Driver's License #: _____
Phone # (where person can be reached during FBC~CW operational hours: _____

Name: _____ Relationship to Child: _____
Driver's License #: _____
Phone # (where person can be reached during FBC~CW operational hours: _____

Name: _____ Relationship to Child: _____
Driver's License #: _____
Phone # (where person can be reached during FBC~CW operational hours: _____

I authorize my child to be released by FBC~CW to the individuals indicated above, in addition to those already listed on this form.

_____ _____
Parent/Guardian Signature **Date**

Enrollment Form, Continued

(Please fill in enrollment form completely and legibly)

Child's Health Information

Does your child have any known allergies? ☐ Yes ☐ No

If yes, what kind? _____

How do these allergies affect your child? *Check all that apply*

☐ Minor irritation ☐ Severe Reaction ☐ Hives ☐ Airway Constriction/Causes Swelling

How are these allergic reactions usually treated? _____

Does your child take any type of daily medication? ☐ Yes ☐ No *If yes, what and how often?*

_____

_____

Other information/instructions FBC~CW needs to know that will be helpful in the care of your child?

_____

_____

Please sign, indicating you have completed your child's health information to the best of your knowledge.

_____ **Parent/Guardian Signature**

_____ **Date**

Information for the Classroom Teachers

Has your child had any other group experiences? *Check all that apply*

☐ Sunday School ☐ Daycare ☐ Play Days ☐ Individual Care

Does your child have separation anxiety? ☐ Yes ☐ No

Does your child have any fears? ☐ Yes ☐ No *If yes, please explain* _____

_____

Are there any pets in the home? ☐ Yes ☐ No

Name: _____ Kind of animal: _____

Name: _____ Kind of animal: _____

Name: _____ Kind of animal: _____

Name: _____ Kind of animal: _____

Is your child potty trained? ☐ Yes ☐ No

If yes, please list the words your child uses to let you know he/she needs to go to the bathroom:

_____

If no, at what age do you plan to plan to begin potty training and what can we do to help?

Enrollment Form, Continued

(Please fill in enrollment form completely and legibly)

Immunization Record

	DTaP	IPV	Hib	MMR	Hep B	Hep A	Varicella	PCV
≤ 2 mos.								
3 mos.	■ x 1	■ x 1	■ x 1		■ x 1			
5 mos.	■ x 2	■ x 2	■ x 2		■ x 2			
7 mos.	■ x 3	■ x 2	■ x 2		■ x 2			
16 mos.	■ x 3	■ x 2	■ x 1	■ x 1	■ x 2			
19 mos.	■ x 4	■ x 3	■ x 1	■ x 1	■ x 3		■ x 1	
25 mos.	■ x 4	■ x 3	■ x 1	■ x 1	■ x 3	■ x 1	■ x 1	
43 mos.	■ x 4	■ x 3	■ x 1	■ x 1	■ x 3	■ x 2	■ x 1	

***Indicates age of child at enrollment; Vaccines are required prior to enrollment**

Physician/Health Statement

Child's Name: _____ **Birthday**: _____

I have examined the above-named child within the past year and find that he/she is physically able to participate in FBC~CW program activities.

_____ _____

Physician's Signature Date

Physician's Address:

_____

Phone #: _____ **Other**: _____

List any medications taken regularly by the child:

_____

Any known allergies? _____

Other special physical conditions? _____

_____

School Age Child

My child attends the following school and his/her immunization record is on file at the school. Are all immunizations current? □ Yes □ No

Name of school: _____ **Grade**: _____

Parent Signature **Date**