
# MDO Registration Form

1215 N. Von Minden St.
La Grange, TX. 78945 (979) 968 - 8323
mdo@newlifelg.org

## Child:

| First Name | Last Name | Preferred Name |
|---|---|---|
| Full Address | | |
| Sex: ☐ Male ☐ Female | Birthdate | Primary Language |

## Mother:

| First Name | Last Name | |
|---|---|---|
| Full Address | | |
| Cell # | Home # | Work # |
| E-mail | Employer | Occupation |

## Father:

| First Name | Last Name | |
|---|---|---|
| Full Address | | |
| Cell # | Home # | Work # |
| E-mail | Employer | Occupation |

In the event of an emergency, and parents cannot be reached,
please provide additional emergency contacts

| Name | Phone | Relationship |
|---|---|---|
| | | |
| | | |

**Please notify MDO director is someone other than you will be picking up your child.**
**Photo ID will be required.**

As the parent or legal guardian of the child listed above, I permit him/her to participate in the ministries of New Life Methodist Church.

Please Initial Below:

____ I knowingly release, absolve, indemnify and hold harmless New Life Methodist Church, it members, trustees, administrative board, committees, and staff as well as organizers, workers, and all others acting on behalf of New Life Methodist Church or its programs and activities from all claims that might result from any accident, personal injury, illness or death to the child named above.

____ I understand that as a participant, my child may be photographed or videotaped during activities and that this media may be used in promotional materials.

____ In the event I cannot be reached to make arrangements for emergency medical attention my signature authorizes the adult in charge to administer or authorize the administration of emergency medical treatment in case of illness or injury to my child named above, and I assume all financial liability.

____ I understand I am responsible for the monthly tuition and the late fees will be charged after the 10th of the month.

Parent / Guardian Signature _____ Date _____

Parent / Guardian Signature _____ Date _____

Because New Life Mother's Day Out operates only two days per week, we are not required to be licensed by the Texas Department of Child Protective Services (SCPS). However, the standards and guidelines we follow for our facilities, our curriculum, and our childcare providers are of the highest quality, equaling or exceeding those promulgates by the DCPS.

# New Life Methodist Mother's Day Out


## Registration Packet:

**Mother's Day Out Program 2026-2027**

**Registration Date:** _____

## Participant Information :

**Participant Name:** _____

**Date of Birth:** _____ **Age:** _____

**Gender:** _____

**Home Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Parent/Guardian:** _____

**Relationship:** _____

**Phone:** _____

**Email:** _____

**Parent/Guardian:** _____

**Relationship:** _____

**Phone:** _____

**Email:** _____

## Emergency Contact:

**Primary Emergency Contact**

Name: _____

Relationship to Participant: _____

Phone (Primary): _____

Phone (Alternate): _____

Email: _____

**Secondary Emergency Contact**

Name: _____

Relationship to Participant: _____

Phone (Primary): _____

Phone (Alternate): _____

Email: _____

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## Authorized Pickup:

The following individuals are authorized to pick up my child.

| Name | Relationship | Phone Number |
|---|---|---|
| | | |
| | | |
| | | |

## Unauthorized Pickup:

The following individuals are NOT authorized to pick up my child.

| Name | Relationship | Phone Number |
|---|---|---|
| | | |
| | | |
| | | |

# Medical & Health Information:

## Allergies

Please list all known allergies (food, medication, environmental, insect, etc.) and describe reactions.

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□ **No known allergies**

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## Immunizations

Are immunizations current?

□ Yes

□ No

□ Exempt (Please explain): _____

## Medical Conditions

Please list any medical conditions, diagnoses, or special health concerns.

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□ **None**

## Medications

Is the participant currently taking any medication?

□ Yes □ No

If yes, please list:

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## Physician Information:

Primary Physician: _____

Clinic Name: _____

Phone Number: _____

Address: _____

Preferred Hospital: _____

Dentist (Optional): _____

Phone: _____

## Insurance Information:

Insurance Company: _____

Policy Holder: _____

Relationship to Participant: _____

Policy Number: _____

Group Number: _____

Insurance Phone Number: _____

## PERMISSIONS & SIGNATURES

### Medical Release Authorization

I authorize the staff of this organization to obtain emergency medical treatment for my child if I cannot be reached. I understand every reasonable effort will be made to contact me before treatment whenever possible. I accept responsibility for any medical expenses incurred.

Parent/Guardian Name: _____

Signature: _____

Date: _____

## Photo & Media Waiver

I grant permission for photographs, video recordings, and other media containing my child to be used for promotional, educational, and informational purposes, including print materials, social media, and the organization's website.

□ Yes, I give permission.

□ No, I do not give permission.

Parent/Guardian Signature: _____

Date: _____

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## Liability Waiver

I understand participation in program activities involves inherent risks. I voluntarily allow my child to participate and agree to release and hold harmless the organization, its employees, volunteers, and representatives from liability for injuries or damages except where prohibited by law or resulting from gross negligence or willful misconduct.

Parent/Guardian Signature: _____

Date: _____

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## Financial Agreement

I understand I am responsible for all tuition, fees, and charges associated with enrollment.

I agree to:

- Pay all required registration and program fees according to the organization's payment schedule.
- Pay any applicable late fees or returned payment fees.
- Provide written notice of withdrawal according to organization policy.
- Understand that refunds are subject to the organization's refund policy.

Parent/Guardian Signature: _____

Date: _____

## Additional Notes:

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## OFFICE USE ONLY

Registration Received By: _____

Date: _____

Payment Received: □ Yes □ No

Amount: _____

Notes: