

First Baptist Church
 Mother's Day Out Program
 210 S. Morgan Avenue
 Broussard, LA 70518
 (337) 837-1112 FAX: (337) 837-3728
 Lisa Ledet, Director

2019 Summer Registration

Child's Name: _____ Birthdate: _____ Sex: _____

	Mother	Father
Name		
Street Address		
City, State, ZIP		
Phone #		
Email Address		
Employer		
Work Phone #		

Parents' Relationship to Each Other: Married Divorced Separated Single
 (If divorced, a copy of the Divorce Decree noting guardianship, days of visitation, etc., must accompany this form.)

Child lives with (please check all that apply): Mother and Father Mother Father Other
 If other, please describe _____.

Summer session enrollment is three days a week: Tuesday, Wednesday, and Thursday

Preferred session: June _____ July _____ Both sessions _____
 (June 4 - 27) (Jul 9 - Aug 1)

Registration Fee (Non-refundable): \$50.00

Tuition: \$245.00 per month

Optional Information: Family Religious Preference _____

Church Membership _____

How did you find out about our program? _____

(Front)

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I understand that my child will only be released to the parents listed on the front of this form and to the individuals listed below. I understand that this list can be updated as needed throughout the school year. Individuals listed will be required to show identification. THESE INDIVIDUALS MAY ALSO BE CONTACTED IN CASE OF AN EMERGENCY IF WE ARE UNABLE TO CONTACT PARENTS.

I authorize that my child, _____, be released by the First Baptist Church Mother's Day Out Program to the following individuals:

Name	Relationship to Child	Phone Number

For the following questions, please briefly explain "Yes" answers in the space provided.

Does your child have any food allergies? Yes No _____

Does your child have any dietary restrictions? Yes No _____

Does your child have any other allergies? Yes No _____

Does your child have any medical conditions? Yes No _____

Child's Doctor: _____ Doctor's Phone #: _____

Child's Dentist: _____ Dentist's Phone #: _____

I authorize First Baptist Church Mother's Day Out Program to secure emergency medical treatment for my child.

Parent's Signature: _____ Date: _____

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