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

2020-2021 School Year 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 _____.

Please check preferred days: Monday _____ Tuesday _____ Wednesday _____ Thursday _____

Registration Fee (Non-refundable): $100.00 (only/first child), $75.00 (siblings)

Monthly Tuition: 2 days per week - $185.00 / 3 days per week - $245.00 / 4 days per week - $295.00

Curriculum Fees: 2 year olds - $40.00 / 3 year olds - $50.00 / 4 year olds - $70.00

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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