FIRST BAPTIST WEESCHOOL
Registration Form 2019-2020

Child's Full Name_____

Sex_____ Birth Date _____ Age as of Sept.1, 2019 _____

Address_____

Home Telephone_____

Mothers' Name _____Cell#_____

Email Address_____

Mothers'Employer_____Work#_____

Address_____

Fathers' Name_____Cell#_____

Fathers' Employer_____Work#_____

Address_____

Person Responsible For Tuition Payment _____

Are you a member of any Church Yes ( ) No ( )

Church Membership at, if yes_____

Emergency Contacts-other than mother or father:

Name_____ Contact Number_____

Name_____ Contact Number_____

Name_____ Contact Number_____

Name of Physician_____ Number_____

Insurance Company_____ Policy Number_____

Allergies_____

Special Needs_____

I give permission for my child _____ to be treated by authorized medical personnel in the event of an emergency. I, therefore, hold free from liability First Baptist WeeSchool and all attending medical personnel acting according to accustomed procedure and rendering general and special medical related treatment on the behalf of and for the goodwill of my child (legal ward).

_____ _____

(Parent Signature) (Date)

For office use only:
Class Assignment:_____ ***Records Received:***_____
Registration Payment Type:_____
Date Paid:_____