

FIRST BAPTIST WEESCHOOL
Registration Form 2024-2025

Child's Full Name _____

Sex _____ Birth Date _____ Age as of Sept.1, 2024 _____

Address _____

Mothers' Name _____ Cell# _____

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 of Physician _____ Phone 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)

