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First Baptist Church Mother's Day Out Enrollment Year______________

325 W. McCarty Lane, San Marcos, TX 78666

Child's Name:___________________________Name Child Prefers:______________________

Home Address: _____________________________________City/Zip:_____________________

Best Phone:____________________________Birthday:________________________M/F______

Email Address:____

Mother/Guardian	**Father/Guardian**
Name:_______________________________	Name:_______________________________
Employer:_____________________________	Employer:____________________________
Work Phone:_________________________	Work Phone:________________________
Cell:________________________________	Cell:_______________________________
Driver's License:______________________	Driver's License:______________________

Emergency Contact/Transportation Authorization

One contact, other than the parents, is required for registration. If the parents are unavailable, the following individual has permission to transport and seek care for this child. You may also authorize additional people to pick up your child. They will be required to show an I.D.

Name	Address	Phone (home/work/cell)

Allergies/Medications

My child is known to have allergic reactions to:

Allergen	Reaction	Treatment

I give the director permission to administer one of the following medications to my child in case of emergency:

Children's Benadryl yes( ) no( )   Children's Tylenol yes( ) no( )   Neosporin yes( ) no( )

Office Use Only:

Registration/Supply Fee Received $______________ Tuition $_______________All Forms Received__________

Assigned to Class:

3-9 Months   1 0-16 Months   17-23 months   24-28 months   29-36 months   3a Years   3b years   4 Years

General Health Information

Child's Name____

Medical Conditions

Describe any medical conditions that your child may have, and how you would like our staff to respond. Please include any past serious illnesses or injuries, disabilities and hospitalizations that have occurred in the past 12 months.

Medical Condition　　　　　　　　　　　　Response Procedure

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Medications

Please list any medications prescribed for long-term, continuous use.

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Medical Authorization

Should my child require medication brought from home, I authorize FBC MDO staff to administer this medication to my child. I understand that I must also sign the medication chart in the FBC MDO office each time medication is required and I understand that all medication must be in the original container and labeled appropriately.

*Parent/Guardian Signature*____

Well Check

I understand that a requirement for participation in the program is a doctor's examination and a TB screening every 12 months. I understand that I must present a statement each year from my child's doctor within one week of admission to verify that my child is physically able to participate in the day care program. This may be on the doctor's own letterhead and can be faxed to the 392-9688, Attention FBC MDO.

*Parent/Guardian Signature*____

Emergency Medical Release

In the event that I cannot be reached or cannot make arrangements for emergency medical attention at the time of illness or accident, I hereby authorize FBC MDO to transport my child to the closest medical facility and authorize the medical providers to provide the necessary treatment.

Doctor ____________________Address __________________________Phone_____________

Hospital_Christus Santa Rosa_Address_1301 Wonderworld Drive____Phone_353-8979 (911)

*Parent/Guardian Signature*____

The following items are due at registration:

Non-refundable Registration/Supply Fee $________________
Complete Registration Forms.

The following items are due the first day of class:
Well Check
Immunization Record/Exemption Form

I have read the FBC MDO Parent Handbook I agree to abide by all FBC MDO policies as outlined.

Parent/Guardian Signature ____*Date*_____________