



6209 West Ave
San Antonio TX
78213

210-344-7188

REGISTRATION 2011 - 2012

CHILD'S FIRST NAME MIDDLE LAST NAME

PREFERRED NAME DATE OF BIRTH MALE FEMALE

MOTHER'S NAME FATHER'S NAME

STREET ADDRESS CITY STATE ZIP

HOME PHONE MOTHER'S SECONDARY PHONE FATHER'S SECONDARY PHONE

EMAIL HOME CHURCH

DOES YOUR CHILD HAVE ANY ALLERGIES? _____ IF YES, PLEASE LIST ALLERGIES. _____

IN CASE OF ILLNESS OR ACCIDENT THAT DOES NOT REQUIRE EMERGENCY TREATMENT, THE CHLD MAY BE RELEASED TO THE FOLLOWING PERSONS (OTHER THAN PARENTS):

NAME PHONE

ADDRESS RELATIONSHIP

NAME PHONE

ADDRESS RELATIONSHIP

NAME PHONE

ADDRESS RELATIONSHIP

HELPFUL INFORMATION

WHEN I CRY, SOMETHING MY MOMMY DOES TO COMFORT ME _____

FAVORITE TOY _____ SONG _____

OTHER COMFORTING INFORMATION/INSTRUCTIONS _____

BROTHERS/SISTERS

NAME _____ AGE _____

NAME _____ AGE _____

NAME _____ AGE _____

PARENTAL AGREEMENT

I, _____ have read the Mother's Day Out Parent Handbook and agree to abide by these policies. I agree to honor the non-refundable fee and monthly tuition payment schedule. In the event I need to withdraw my child from the program, I agree to give two weeks notice or pay the two-week period. By signing this form, I am agreeing to abide by these policies.

Castle Hills Christian Church Mother's Day Out Ministry agrees to furnish preschool child care each Tuesday and Thursday except for those days noted in the policies/Ministry calendar. The parent will pay the amount agreed upon no later than the 10th of the month regardless of the number of days the child actually attends.

EMERGENCY RELEASE FORM

Please read and sign the following statement:

Should my child become ill or suffer an accident of any character during the time he/she is in the Mother's Day Out Ministry, a representative of Castle Hills Christian Church shall undertake to contact me immediately.

I hereby authorize Castle Hills Christian Church to secure such medical attention and care for my child as may be necessary in case of emergency. I, the undersigned, shall also assume responsibility for any payment.

Your Printed Name: _____

Signature: _____ Date: _____

Your Doctor: _____ Doctor's Phone: _____

Hospital Preference: _____
