New Vision Weekday Preschool
Registration

$75.00 REGISTRATION FEE IS NON-REFUNDABLE _______
Initials

Child's Full Name: ____
(Last) (First) (Middle)

Name child is called: ______________________ Child's Sex: Male ____ Female____

Child's Birth Date: _____/_____/_____ Is your child potty trained? ________

Parents/Guardians:

Mother's Name: ______________________ Father's Name: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________
(City) (Zip Code) (City) (Zip Code)

Home Phone #: ______________________ Home Phone #: ______________________

Cell #: ______________________ Cell #: ______________________

Work #: ______________________ Work #: ______________________

Employer: ______________________ Employer: ______________________

E-Mail Address: ______________________ E-Mail Address: ______________________

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Do you hold a membership at a local church? ________ If so, where? ______________________

Are you actively involved in your church? ____________

Would you like to receive information about New Vision Baptist Church? ______________________

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To ensure the safety of your child, list other individuals to whom your child may be released:

Name: ______________________ Name: ______________________

Phone: ______________________ Phone: ______________________

List any individual to whom your child MAY NOT be released:

Name: ______________________ Name: ______________________

Signature of Parent/Guardian ______________________ Date: ______________________

For Office Use Only

School Year: ______________________ Date Received:______________________

Registration Fee: ______________________ Check #: ______________________

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New Vision Weekday Preschool
Emergency Medical Information

Child's Name: ___________________________________ Child's Birth Date: _____/_____/_____

Parents/Guardians:

Mother's Name: ________________________________ Father's Name: _________________________________

Address: ______________________________________ Address: ______________________________________

______________________________________ ______________________________________
(City) (Zip Code) (City) (Zip Code)

Home Phone #: ________________________________ Home Phone #: ________________________________

Cell #: _______________________________________ Cell #: _______________________________________

Work #: ______________________________________ Work #: ______________________________________

If parent/guardian cannot be contacted, list the name of person authorized to act for parent/guardian in case of emergency:

Name: _______________________________________ Relationship to child: ____________________________

Home Phone #: ________________________________ Cell/Work #: ___________________________________

Family Pediatrician: ____________________________ Office #: ______________________________________

Permission is granted to meet the needs of my child in case of any emergency.

____ ____
Signature of Parent/Guardian Date

MEDICAL INFORMATION

Medical Allergies (i.e. penicillin): ____

Food Allergies (i.e. peanut butter): ____

Environmental Allergies (i.e. bee stings): ____

List type and dosage of any medication your child is currently taking: ______________________________________

List any other special medical, diet, or significant information that a medical professional may need to know in order to treat your child properly: ____

Statement of Permission for Medical Treatment

I hereby release unto the director or any other duly recognized representative of the New Vision Weekday Preschool Program all authority and responsibility to authorize any and all medical treatment necessary for the health and well-being of the child named above. This Statement shall authorize any and all medical treatment by licensed medical personnel, pursuant to the express authorization, whether written or oral, of the above mentioned representatives. This Statement is effective inclusively for all activities sponsored by the New Vision Weekday Preschool Program for any and all costs of said medical treatments incurred.

____ ____
Signature of Parent or Guardian Date

____ ____
Notary Public Date

New Vision Weekday Preschool
Health Record

Child's Name: ___________________________________ Child's Birth Date: _____/_____/_____

Please check any of the following that your child has had:

Measles ________ Mumps ________ Chicken Pox ________ Meningitis ________

Flu ________ Convulsions ________ Whooping Cough ________

Is there any evidence of:

Hearing loss or difficulties? ____

Vision difficulties? ____

Speech difficulties? ____

List any:

Hospitalizations: ____

Operations/Surgeries: ____

Other serious illnesses: ____

Does your child have any other medical conditions? Yes ________ No ________

If yes, please specify: ____

Are all immunizations up to date? Yes ________ No ________

If no, indicate reason: ____

******** A copy of the most current immunization record is required.********

New Vision Weekday Preschool
Enrollment/Tuition/Fees Agreement

It is my understanding that my child ____________________________________is enrolled in the New Vision Weekday Preschool program. Monthly tuition of $170.00 is due and payable on the first day of each month. If monthly tuition is not paid by the tenth of the month, a $10.00 late fee per child will be assessed. There is a $75.00 non-refundable registration fee that is due when the registration forms are submitted for enrollment.

Should my child be withdrawn for any reason prior to the end of the preschool year, I agree to submit to the director a written notice of withdrawal two weeks prior to the last day of attendance or agree to pay one additional month of full tuition.

No refunds will be given for withdrawal from the preschool prior to the end of the month or for days missed due to family vacations, illness, weather-related closings, or preschool breaks.

If serious difficulties should arise beyond the control of teachers or parents, which hinder a child from adapting to the classroom environment, New Vision Weekday Preschool is willing that he/she be withdrawn with a refund given for the balance of the tuition for the month.

Signature of Parent/Guardian: ____ Date: _________________

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New Vision Weekday Preschool

The Tennessee Department of Human Services does not require that Preschools/Mother's Day Out/Parent's Day Out programs be licensed. Because of this exemption, this facility, New Vision Weekday Preschool is not a licensed child care facility.

Signature of Parent/Guardian: ____ Date: _________________