

# 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? \_\_\_\_\_ Are you a New Vision staff member? \_\_\_\_\_

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: \_\_\_\_\_ 2020/2021 \_\_\_\_\_ 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, beginning in August and ending in May. 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: \_\_\_\_\_