

Enrollment Information

OFFICE USE ONLY
Date of Admission
Date of Withdrawal

FALL 2022/SPRING 2023 REGISTRATION

First United Methodist Church Mother's Day Out
 1826 Nall Street ♦ Port Neches, TX 77651 ♦ (409) 722-8358
 Allenda Savant, Director

Child's Full Name	Nickname	Complete Date of Birth	Child's Home Telephone Number (409)
Child's Street Address		City	Zip
Parent(s) or Guardian(s) Name(s)			Child's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent's Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single		Church Affiliation	
List telephone numbers where Parents/Guardian may be reached while child is in care:	Mother's Telephone No. Place of Employment/Occupation:	Father's Telephone No. Place of Employment/Occupation:	Guardian's Telephone No. (If different from home number)
Person to call in case of emergency and parent/guardian can't be reached:		Telephone No.	Relationship

I hereby authorize the First United Methodist Church Mother's Day Out to allow my child to leave the facility ONLY with the following persons (NAME & PHONE NUMBER)

1. Name	2. Name	3. Name
Contact #s	Contact #s	Contact #s

PLEASE READ, CHECK, AND SIGN:

WATER ACTIVITIES: I hereby give do not give my consent for my child to participate in water activities (sprinklers and wading pool.) List any limitations/restrictions.

LUNCH POLICY: I understand that in providing the lunch meal, I am responsible for its nutritional value and for meeting my child's daily food needs.

_____ Signature of Parent/Legal Guardian

Does your child have any special needs such as allergies to food, insect bites, or anything else, existing illnesses, prior serious medical conditions, take any medications, or other characteristics which staff should know to serve your child better? No Yes If Yes, please list all information:

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take my child to:

Name of Physician	Address	Phone
Name of Hospital	Address	Phone

I give consent for the facility to secure any and all necessary emergency medical care for my child.

_____ Signature of Parent of Legal Guardian

FOR IDENTIFICATION VERIFICATION ONLY	I WISH TO ENROLL MY CHILD IN THE FOLLOWING PROGRAM	
Father's DL # _____ SS # _____	Mother's Day Out Program 9:00 AM—2:00 PM <input type="checkbox"/> Tuesday Only <input type="checkbox"/> Thursday Only <input type="checkbox"/> Tuesday and Thursday	Registration Fee \$75 (for everyone) Tuition <input type="checkbox"/> \$105/month Tuesday and Thursday <input type="checkbox"/> \$60/month Tuesday Only or Thursday Only <input type="checkbox"/> Additional \$5.00 for Credit Card pmts.
Mother's DL # _____ SS # _____		