

# Enrollment Information

|                    |
|--------------------|
| OFFICE USE ONLY    |
| Date of Admission  |
| Date of Withdrawal |

**FALL 2021/SPRING 2022 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<br><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.<br>Place of Employment/Occupation: | Father's Telephone No.<br>Place of Employment/Occupation: | Guardian's Telephone No.<br>(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

|   |  |   |
|---|--|---|
| <b>FOR IDENTIFICATION VERIFICATION ONLY</b> | <b>I WISH TO ENROLL MY CHILD IN THE FOLLOWING PROGRAM</b>  |   |
| Father's DL # _____ SS # _____              | <b>Mother's Day Out Program</b><br>9:00 AM—2:00 PM<br><input type="checkbox"/> Tuesday Only<br><input type="checkbox"/> Thursday Only<br><input type="checkbox"/> Tuesday and Thursday | <b>Registration Fee</b><br>\$60 (for everyone)<br><br><b>Tuition</b><br><input type="checkbox"/> \$95/month Tuesday and Thursday<br><input type="checkbox"/> \$55/month Tuesday Only or Thursday Only |
| Mother's DL # _____ SS # _____              |  |   |