Abundant Life Ministries Mother's Day Out (ALMMDO)

A Ministry of Sylvan Hills First Baptist Church

9008 HWY 107, Sherwood, AR 72120 – office: 501-835-2204 Fax: 501-835-8732

2019 - 2020 Registration Form

Child's Name: ____ **Date of Birth**:____________________

Last First Middle mm/dd/yyyy

Address: _____________________________ ________________ ______ _________ Gender: M_____F_____

Street City State Zip

Home Phone ( ) ___________-______________________Email:______________________________________

Has your child ever been registered with ALMMDO before? Yes ____ No ____

How did you hear about ALMMDO? ____________________

Has your child ever been enrolled at other childcare facilities? Yes ____ No ____If yes where?__________________________

Are you a member of Sylvan Hills First Baptist Church? Yes ____ No ____

If no, what church do you attend? ______________________

Is your child potty trained? Yes________No_______A child is considered potty trained when he/she has mastered using the toilet, wears underwear/panties, and no longer needs diapers/pull-ups for bathroom accidents.

Child Resides With (Check one): Both Parents__________M____________Step Parent_________Grandparent__________Guardian______

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Father/Guardian Name: ____ (____)____-___________

Last First Middle Cell Phone

Address if different from child: ____

Employment:: _________________________ Work Hours:_______________Work Phone (______)_______-__________

- Emergency Contact (check one): ( ) yes ( ) no
- **Authorized to pick up child (check one): ( ) yes ( ) no**
- Responsible for paying payments (check one): ( ) yes ( ) no

Mother/Guardian Name: ____ (____)____-___________

Last First Middle Cell Phone

Address if different from child: ____

Employment: __________________________Work Hours:__________________Work Phone: (_______)______-___________

- Emergency Contact: (Check one): ( ) yes ( ) no
- **Authorized to pick up child: (Check one): ( ) yes ( ) no**
- Responsible for paying payments (check one): ( ) yes ( ) no

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Medical Information:

Child's Physician: ______________________ Physician Phone ( )_____-_________ Hospital Preference: ________________

List known allergies: ____**Severity of allergy: Mild___Moderate____Severe____**

Treatment for Allergy: Antihistamine ________ Other: ____________Milk or Formula Preference:___________________________

Medical conditions/impairments, and behavioral concerns: ____

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Person authorized to act for parents in case of emergency and is authorized to pick up child:

Contact Name: ____ Relationship to Child: ____________________________________

Address: ____
Street City State Zip
Home#: _______________________________ Cell #:__________________________ Work #: _____________________________

Contact Name: ____ Relationship to Child: ____________________________________

Address: ____
Street City State Zip
Home #: ________________________________ Cell #:____________________________Work #: _____________________________

Persons authorized to pick up child not mentioned above*

Contact Name: _________________________ Relationship to Child: ____________________Contact #__________________________

Contact Name: _________________________ Relationship to Child: ____________________Contact #__________________________

****No child will be permitted to leave ALMMDO with any person other than the person authorized by parent/guardian to pick up child. Please inform all authorized people picking up child that photo ID will be requested to confirm authorization.***

Please Circle the Days You are interested in:

Monday's Tuesday's Wednesday's Thursday's

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Consent for Emergency Medical Care:

I _____________________, do hereby request and give consent to the director of Abundant Life Ministries Mother's Day Out or her duly appointed representative for ___________________ to receive such medical or surgical aid, as may be deemed necessary and expedient by a duly licensed or recognized physician in case of an emergency when the parent/guardian or other emergency contact could not be reached. I also give permission for transportation of the child for emergency treatment.

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Photography/Video

Pictures are only taking for classroom or newsletter purposes. Photographs are not shared with any source of social media or advertising. Video: Each classroom is under video surveillance on a daily basis. The monitor to view all 5 classrooms is located in the Director's office. The cameras are used for daily viewing purposes only and will not be put on the internet or any social media.

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Your signature indicates that you have read and understand ALL information in the parents handbook provided upon registration. By signing this you also understand that a current immunization record is required by the Department of Human Services, Division of Child Care and Early Childhood Education, Licensing Division.

Print Name (First & Last)_____________________________________Signature:____________________________Date:____________

To complete registration please submit:

- *$50.00 non-refundable annual registration fee*
- *Copy of Current immunization record (New Students)*
- *Returning students turn in immunization record if it's been updated*
- *2019-20209 Registration Form Completed* ****Does not guarantee enrollment****

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Office Use Only:

Assigned Classroom: Nursery 1 Nursery 2 Toddler Preschool 1 Preschool 2 **Classroom Rate**: $______________________________

Method of Reg payment: :_____________________Amount paid:____________________________Date paid:______________________

Interested In Before Care? _________________ Interested in After Care? _________________ Interested in both?___________________