



Fellowship Day School

2010-2011 Registration Form

FOR OFFICE USE ONLY

Reg. Amt. _____

Cash _____ Check # _____

Please indicate class choice:

Twos T/TH

Pre-K M – TH

Twos T/TH/F

Pre-K M – F

Threes M/W/F

Kindergarten M - F

Threes add-on-day(s) -Tues. ,

Thurs. , or both

Child's Name _____

(Please list first name to be called and last name only)

Home Address _____

_____ Zip _____

___ Male ___ Female

Date of Birth _____

Mother's Name _____ Home Phone _____

Place of Employment _____ Work Phone _____

Occupation _____ Cell Phone _____

E-mail Address (optional) _____

Father's Name _____ Home Phone _____

Place of Employment _____ Work Phone _____

Occupation _____ Cell Phone _____

E-mail Address (optional) _____

If your child becomes ill or has an accident, we will first call the parents. If neither can be reached, we will call the contacts as listed below:

1) Name _____ Relationship _____

Home Phone _____ Cell/Work Phone _____

2) Name _____ Relationship _____

Home Phone _____ Cell/Work Phone _____

Please inform these individuals that they are an emergency contact for your child, and that they have your permission to pick up your child from school. **(OVER)**

Child's Physician _____ Phone _____

Hospital Preference _____

Does your child take prescribed medication? _____ Please list _____

Is your child allergic to any medication or food? _____ Please list _____

Siblings (List names and ages) _____

Religious Affiliation _____

Please share your child's personality with us:

Does your child experience pronounced difficulty in any area? (Examples - separation anxiety, medical problems (including physical disabilities), difficulties getting along with peers, etc.):

Please include anything else that you would like to share with us about your child, or expectations that you may have regarding your child's experience at Fellowship Day School:

I understand that a registration fee of \$70 must accompany this registration form (\$50 for each additional sibling), and that this registration fee is non-refundable.

Parent's Signature _____ Date _____

Please turn in a copy of your child's immunization records from your doctor before school begins. Your doctor's office may fax your records to us at 288-3011.

MEDICAL CONSENT AND LIABILITY RELEASE
Fellowship Day School

I, the parent of _____ do hereby relieve Fellowship Presbyterian Church and all employees of Fellowship Day School from any liability or fault due to any accident or illness that may occur to said child while said child is in attendance of the Day School, and/or School of the Arts programs. Be it further agreed that said parent gives any and all employees in charge on that day that said child is in attendance, permission to grant to any and all medical personnel the right to treat said child for any accident or illness in the event that said parent(s) cannot be reached before treatment is considered necessary. The decision that treatment is necessary will be based on the opinion of a licensed physician. Said parents do hereby relieve any and all employees of Fellowship Day School, and/or Fellowship School of the Arts of any liability in connection with the medical treatment to said child.

Parent's Signature: _____ Date: _____

FIELD TRIP RELEASE FORM
Fellowship Day School

I, the parent of _____ give my permission for my child to attend field trips approved by the Director of Fellowship Day School. I understand that parents are welcome to attend field trips, but if one cannot attend, another parent or teacher will be assigned to take care of my child. Fellowship Day School or parents attending the field trip will not be held responsible financially or otherwise if any accidents or mishaps occur on a Fellowship Day School field trip.

An additional form will be sent home describing each class field trip, to be signed and returned, requiring your permission several days before a trip is taken.
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Parent's Signature: _____ Date: _____