

# First Baptist Church of Rockmart Preschool Registration 2024



Dear Families,

Enrollment for 2024-2025 preschool year is now open! We are so excited you have chosen to join our First Baptist Church Preschool family. Please note that we will maintain small class sizes to accommodate our vision of a family atmosphere with a low student to teacher ratio. Because of this, spaces are limited.

Registration is \$40.00 per newly enrolled student, and \$25 for re-enrolling students. This is due with the registration form to ensure a seat in the class. The registration fee is non-refundable and includes a school shirt.

Registration deadline is May 1, 2024. Registration forms may be downloaded from [firstbaptistrockmart.org](http://firstbaptistrockmart.org) or picked up from the church office (Monday- Thursday 9:00-4:00).

The first day of preschool will be August 8, 2024. Monthly tuition is \$150.00. Student's age on September 1, 2024 will determine their class placement. Classes will be Tuesday- Thursday. Drop off 7:45 and pick up by 11:45.

If you would like to see the types of activities and events we have during the year, check out our Facebook page! We look forward to loving and serving your family in the upcoming school year!

Completion of this agreement is required for enrollment. This form will enable us to better understand your child and meet his/her needs..

<b>Child Information</b>				
Child's first name		Child's middle name		Child's last name
Child's nickname				
DOB	Sex	Child's primary language		Parent/guardian's primary language
Child's home address			City	State
<b>Family Information</b>				
List family members your child lives with - include first names, relation and ages of siblings				
Parent/guardian		Relationship to child		Home phone
Cell phone				
Home address if different from above			City	State
Zip				
Home email		Work email		work phone
Employer		Employer address		City
State		Zip		
Other parent/guardian		Relationship to child		Home phone
Cell phone				
Home address if different from above			City	State
Zip				
Home email		Work email		work phone
Employer		Employer address		City
State		Zip		
<b>Child Emergency Contact and Release Information (do not include parents/guardians)</b>				
Please notify FBCP if an Emergency Release Contact will pick up your child on a given day. [For the safety of your child, we request that all authorized pick up persons with whom staff is not familiar provide a photo ID at the time of pick up.]				
Person #1		Relationship to child		Phone
Additional Phone				
Home address			City	State
Zip				
Home email		Work phone		
Person #2		Relationship to child		Phone
Additional Phone				
Home address			City	State
Zip				
Home email		Work Phone		
Person #3		Relationship to child		Phone
Additional Phone				
Home address			City	State
Zip				
Home email		Work phone		

The persons designated in this section will be contacted by us if you cannot be reached in the event of a medical or other emergency. Our staff will only release your child to you or to those persons listed above. If you want a person who is not identified above to pick up your child, you must notify our staff in advance, in writing. Your child will not be released without prior authorization.

Parent initial \_\_\_\_\_ Staff initial \_\_\_\_\_ Date \_\_\_\_\_

**Medical Information**

Please circle your response

1. Does your child have any special medical conditions? No Yes Explain: \_\_\_\_\_
2. Does your child have any chronic illnesses? No Yes Explain \_\_\_\_\_
3. Please list a brief history of your child's serious injuries and hospitalizations. \_\_\_\_\_
4. Does your child have diabetes? No Yes *If yes, please attach care instructions from your physician.*
5. Does your child have asthma? No Yes *If yes, please attach care instructions from your physician.*
6. Will medication be administered regularly? No Yes *If yes, please attach care instructions from your physician.*
7. Does your child have any special dietary needs? No Yes Explain: \_\_\_\_\_
8. Is your child able to fully participate in all activities? Yes No If no, explain: \_\_\_\_\_
9. Does your child have any physical restrictions? No Yes If yes, explain: \_\_\_\_\_
10. Does your child function at the level of other children in his/her age group? Yes No. If no, explain: \_\_\_\_\_
11. Is your child toilet trained? No Yes
12. Does your child use any special equipment, such as a breathing machine, wheelchair, hearing aid, braces, glasses etc.? No Yes Explain

**Illness History**(please check all that apply)

- |  |                                    |                                |
|--|------------------------------------|--------------------------------|
| <input type="checkbox"/> Vision problems           | <input type="checkbox"/> Allergies | <input type="checkbox"/> Other |
| <input type="checkbox"/> Hearing problems          | <input type="checkbox"/> Seizures  |                                |
| <input type="checkbox"/> Nosebleeds                |                                    |                                |
| <input type="checkbox"/> Sore throats              |                                    |                                |
| <input type="checkbox"/> Skin rashes               |                                    |                                |
| <input type="checkbox"/> Ear infections            |                                    |                                |
| <input type="checkbox"/> Asthma/breathing problems |                                    |                                |
| <input type="checkbox"/> Urinary tract infections  |                                    |                                |

*Please attach care instructions from your physician for any of these illnesses.*

Allergies(please list)

Medication Allergies	Reaction	Food Allergies	Reaction
_____	_____	_____	_____

Bee Stings Allergies \_\_\_\_\_  
 Reaction \_\_\_\_\_

Other Allergies	Reaction	<b>Are any of these allergies life-threatening?</b>	<b>Yes</b>	<b>No</b>
_____	_____			

*Please attach care instructions from your physician for any life-threatening allergies.*

To the best of my knowledge the information contained above is accurate. Parent initial \_\_\_\_\_  
 FBCP staff initial \_\_\_\_\_ Date \_\_\_\_\_

**Child's Medical Care Provider**

Primary physician's name

Physician's practice address

Preferred hospital/clinic for emergency care \_\_\_\_\_

**Child's Immunization History: Please provide a copy of your child's immunization records**

**Additional Medical Policies**

- 1. Prior to enrollment, I must provide FBCP with updated medical and immunization information for my child. This information will be updated as needed.
- 2. I agree to provide information to FBCP about my child's conditions, illnesses, allergies or other needs.
- 3. If my child becomes ill with a reportable contagious disease, I understand that he/she will not be able to return until I bring in a physician's note stating that he/she is no longer contagious.
- 4. If my child becomes ill during his/her time at FBCP, the staff will contact me to pick up my child. I will arrange for pick up as soon as possible after being contacted. If I cannot be reached, the staff will contact those listed in the *Child Emergency Contact and Release*.

**Emergency Medical Release and Consent**

In case of a medical emergency, the FBCP staff will attempt to contact me, those listed in the *Child Emergency Contact and Release*, and lastly my physician.

In case of a medical emergency, I permit the transportation of my child to a local hospital or other urgent care facility, if necessary by paramedics or other emergency personnel.

In case of a medical emergency, I agree that my child may receive first aid and/or CPR.

In case of a medical emergency, I will be responsible for the emergency medical expenses.

In case of an accidental ingestion of a poisonous substance, I consent to my child being treated as directed by the Poison Control Center.

Parent signature \_\_\_\_\_ FBCP staff initial \_\_\_\_\_ Date \_\_\_\_\_

**Media Release**

Occasionally, photos will be taken of the children at the center for use within the center or on our website and/or newsletters. Please indicate that you authorize the use and reproduction of photographs of your child in conjunction with the program.

Parent initial: \_\_\_\_\_ FBCP staff initial: \_\_\_\_\_ Date: \_\_\_\_\_

**Agreement Acknowledgement**

I certify that I have read, understand and accept all the terms and conditions described in this Enrollment Agreement.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_ FBCP Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

# First Baptist Church Preschool

## Notice of Exemption

I, \_\_\_\_\_ acknowledge that I have been informed that First Baptist Church Preschool, Rockmart, Ga is not a licensed childcare facility. I also understand this program is not required to be licensed by the Georgia Department of Early Care and Learning and this program is exempt from state licensure requirements.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_