2024-25 **Tue ___ Thurs ___**

First Baptist Church -Joelton

MOTHER'S DAY OUT REGISTRATION FORMS

Please complete all forms and return with a non-refundable $75 registration fee for each child.

***** A current immunization/health form must be included with registration for all students *****

Child's Full Name_____ **Male**___ **Female**___

Preferred Name_____ **Date of Birth** _____ **Age** (as of 8/15/24) _____

PARENT/GUARDIAN CONTACT INFORMATION: (Please fill in all sections)

Mother's Name: _____ Father's Name: _____

Home Address: _____ Home Address: _____

_____ _____

City Zip City Zip

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

E-mail: _____ E-mail: _____

Home church: _____ Home church: _____

Employer: _____ Employer: _____

Employer Address: _____ Employer Address: _____

_____ _____

City Zip City Zip

Work Phone: _____ Work Phone: _____

Work Hours: _____ Work Hours: _____

TRANSPORTATION PLAN: person's (other than parents) to whom your child may be released and are authorized to provide transportation for your child

Name _____ Home phone _____ Cell _____
Relationship to child _____

Name _____ Home phone _____ Cell _____
Relationship to child _____

Parent Signature: _____ Date: _____

EMERGENCY INFORMATION 2024-25

EMERGENCY CONTACT: (authorized to act on parent's behalf if parents are unreachable in an emergency)

Name_____ Relationship_____

Home phone _____ Cell _____ Work _____

Address _____ City_____ Zip_____

MEDICAL INFORMATION: (Please fill in completely)

Child's Physician:
Name: _____
Address: _____
Phone: _____
* Medical concerns/conditions: _____
* Current medications: _____

Child's Dentist:
Name: _____
Address: _____
Phone: _____

Allergies: _____
Treatment required: _____

For life-threatening allergies, we must have care instructions from the physician on file

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CONSENT AND AUTHORIZATION FOR MEDICAL TREATMENT 2024-25

I hereby give my consent to First Baptist Church- Joelton Mother's Day Out to act on my behalf in a medical emergency. I understand that every reasonable effort will be made to notify me. If I am unreachable, the emergency contact person noted on my child's registration form will be contacted.

Preferred Hospital: _____

Parent Name (please print): _____

Parent Signature: _____ Date: _____

Child's Name _____

Getting to know your child- MDO- 2024-25

Eating habits:

1. At what time does your child eat: Breakfast_____ Lunch_____
2. Does your child feed him/herself? Yes_____ No_____
3. Food favorites: _____
4. Food dislikes: _____
5. Food Allergies: _____
6. Dietary restrictions: _____

Sleep habits:

Morning nap? Yes____ No____ Afternoon nap? Yes____ No____
Naps from: _____ to _____ Naps from: _____ to _____
Special blanket, lovie etc.? _____

Toilet habits:

Does your child tell you when they need to go? Yes ____ No____
~Typical time of bowel movement: _____
Are they able to wipe by themselves or need assistance? _____
Wear a pull-up/diaper at naptime? (if potty training) _____

Speech and Physical Development:

My child talks: ____ Well ____Fairly well ____Not very well ____ Not at all
Crawling? Yes ____ No ____ Walking? Yes ____ No ____
Any concerns about speech or physical development?
If yes, what are your concerns? _____

Social Development:

How would you describe your child?
___Outgoing ___ Shy ___Quiet ___Talkative ___ Active ___ Happy ___Grumpy
Is your child around other children on a regular basis? _____
Do you have any concerns about their social development? _____
If yes, what are your concerns? _____

Any other information about your child that would help us in caring for them?

_____

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