

Child's Name: _____

Male Female Date of Birth: _____

2012-2013 Registration Packet

Age as of September 1, 2012:		Start Date:	
Prefers to be called:		Program: <input type="checkbox"/> 9 Months (Aug-May) <input type="checkbox"/> 12 Months	
Local Home Address:		Schedule: <input type="checkbox"/> 7a-6p <input type="checkbox"/> 9a-6p <input type="checkbox"/> 7a-2:30p <input type="checkbox"/> 9a-2:30p	
City, State, Zip:		<i>PRE-K ONLY</i> <input type="checkbox"/> 7a-6p <input type="checkbox"/> 8a-6p <input type="checkbox"/> 7a-2:30p <input type="checkbox"/> 8a-2:30p	
Primary language spoken in home:			
<i>Primary parent contact will receive monthly tuition statement</i>		<input type="checkbox"/> <i>Primary</i> PARENT	<input type="checkbox"/> <i>Primary</i> PARENT
First and Last Name			
Relationship to child			
Address (if different from child)			
Email			
Employer			
Cell		<input type="checkbox"/> <i>Primary</i>	<input type="checkbox"/> <i>Primary</i>
Work		<input type="checkbox"/> <i>Primary</i>	<input type="checkbox"/> <i>Primary</i>
Home		<input type="checkbox"/> <i>Primary</i>	<input type="checkbox"/> <i>Primary</i>

Emergency Contacts & Releases

- **Parents are contacted first in emergency situations.**
- Please list contacts in the order to be contacted in case of an emergency if parents cannot be reached.
- **AT LEAST ONE LOCAL EMERGENCY CONTACT MUST BE LISTED!**
- Mark contacts as *release only* if you do not wish for them to be contacted in an emergency.
- Students will only be released to parents and persons authorized below by the parent.
- Release contacts must be 18 years of age and able to provide photo ID upon pick-up.

Release Only	Emergency Contact /Release	NAME	PHONE	RELATIONSHIP TO CHILD
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			

I hereby give consent for...

- Yes No **School Directories:** my family's contact information to be published in the school directory and/or a classroom directory.
- Yes No **Media:** photographs or videos taken of my child to be used for the purpose of education, information, training, and publicity, including, but not limited to the BMWS website.
- Yes No **Mosquito Repellent & Sunscreen:** BMWS employees and volunteers to apply sunscreen and/or mosquito repellent that I provide to my child before participating in outdoor play.
- Yes No **Water Activities:** my child to participate in water activities: sprinkler play, water table.

How were you referred to BMWS?

- Returning family Parent/Family? _____ Bethany United Methodist Church
- Publication/Ad? _____ Internet _____ Other? _____

I certify the information provided is true and complete to the best of my knowledge and belief. I understand I am responsible for updating information changes in a timely manner to ensure BMWS remains in compliance with all state requirements.

Signature of Parent/Guardian _____ Date _____



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Emergency Medical Release

Parent _____ Relationship _____ Phone _____

Parent _____ Relationship _____ Phone _____

In the event that I cannot be reached to make arrangements for emergency care, I authorize BMWS to take my child or to secure emergency medical transportation for my child to:

	Child's Physician	Preferred Hospital
Name		
Address, City, Zip		
Phone		

The undersigned hereby understands and acknowledges that medication and emergency medical procedures may be administered to a child only with written authorization of a licensed physician, parent, or legal guardian. In consideration of the foregoing, the undersigned hereby authorizes Bethany Methodist Weekday School and/or its authorized representatives to seek and approve appropriate emergency medical attention for the child listed above.

Signature of Parent/Legal Guardian _____ Date _____

Printed Name _____

NOTARY PUBLIC SIGNATURE / STAMP / SEAL REQUIRED

Subscribed and sworn to me this _____ day of _____, 20 _____

Notary Public in and for the State of Texas _____ My commission expires: _____

Physician's Release

The following information must be provided for all students annually **by the child's physician/medical provider.**

- Yes No Existing illness/medical condition _____
- Yes No Known allergies and/or special dietary needs _____
- Yes No Previous serious illness/injuries or hospitalization _____
- Yes No Long term medication _____
- Yes No Diagnosis of physical/mental impairment and/or special needs _____
- Yes No Prohibited activities _____

I have examined this child within the past 12 months and find that he/she is able to participate in the preschool program at Bethany Methodist Weekday School. Date of last examination _____

Physician's Signature _____ Date _____

Attach current copy of child's immunization record.