New Vision Weekday Preschool
Registration

$75.00 REGISTRATION FEE IS NON-REFUNDABLE _____
Initials

Child's Full Name: _____
(Last) (First) (Middle)

Name child is called: _____ Child's Sex: Male ____ Female____

Child's Birth Date: _____/_____/_____ Is your child potty trained? _____

Parents/Guardians:

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

Address: _____ Address: _____

_____ _____
(City) (Zip Code) (City) (Zip Code)

Home Phone #: _____ Home Phone #: _____

Cell #: _____ Cell #: _____

Work #: _____ Work #: _____

Employer: _____ Employer: _____

E-Mail Address: _____ E-Mail Address: _____

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Do you hold a membership at a local church? _____ If so, where? _____

Are you actively involved in your church? _____ Are you a New Vision staff member? _____

Would you like to receive information about New Vision Baptist Church? _____

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To ensure the safety of your child, list other individuals to whom your child may be released:

Name: _____ Name: _____

Phone: _____ Phone: _____

List any individual to whom your child MAY NOT be released:

Name: _____ Name: _____

Signature of Parent/Guardian _____ Date: _____

**********For Office Use Only**********

School Year: _____ Date Received:_____

Registration Fee: _____ Check #: _____

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New Vision Weekday Preschool
Emergency Medical Information

Child's Name: _____ Child's Birth Date: _____/_____/_____

Parents/Guardians:

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

Address: _____ Address: _____

_____ _____
(City) (Zip Code) (City) (Zip Code)

Home Phone #: _____ Home Phone #: _____

Cell #: _____ Cell #: _____

Work #: _____ Work #: _____

If parent/guardian cannot be contacted, list the name of person authorized to act for parent/guardian in case of emergency:

Name: _____ Relationship to child: _____

Home Phone #: _____ Cell/Work #: _____

Family Pediatrician: _____ Office #: _____

Permission is granted to meet the needs of my child in case of any emergency.

_____ _____
Signature of Parent/Guardian Date

MEDICAL INFORMATION

Medical Allergies (i.e. penicillin): _____

Food Allergies (i.e. peanut butter): _____

Environmental Allergies (i.e. bee stings): _____

List type and dosage of any medication your child is currently taking: _____

List any other special medical, diet, or significant information that a medical professional may need to know in order to treat your child properly: _____

Statement of Permission for Medical Treatment

I hereby release unto the director or any other duly recognized representative of the New Vision Weekday Preschool Program all authority and responsibility to authorize any and all medical treatment necessary for the health and well-being of the child named above. This Statement shall authorize any and all medical treatment by licensed medical personnel, pursuant to the express authorization, whether written or oral, of the above mentioned representatives. This Statement is effective inclusively for all activities sponsored by the New Vision Weekday Preschool Program for any and all costs of said medical treatments incurred.

_____ _____
Signature of Parent or Guardian Date

_____ _____

Notary Public Date

New Vision Weekday Preschool
Health Record

Child's Name: _____ Child's Birth Date: _____/_____/_____

Please check any of the following that your child has had:

Measles _____ Mumps _____ Chicken Pox _____ Meningitis _____

Flu _____ Convulsions _____ Whooping Cough _____

Is there any evidence of:

Hearing loss or difficulties? _____

Vision difficulties? _____

Speech difficulties? _____

List any:

Hospitalizations: _____

Operations/Surgeries: _____

Other serious illnesses: _____

Does your child have any other medical conditions? Yes _____ No _____

If yes, please specify: _____

Are all immunizations up to date? Yes _____ No _____

If no, indicate reason: _____

******** A copy of the most current immunization record is required.********

New Vision Weekday Preschool
Enrollment/Tuition/Fees Agreement

It is my understanding that my child _____is enrolled in the New Vision Weekday Preschool program. Monthly tuition of $185.00 is due and payable on the first day of each month, beginning in August and ending in May. If monthly tuition is not paid by the tenth of the month, a $10.00 late fee per child will be assessed. There is a $75.00 non-refundable registration fee that is due when the registration forms are submitted for enrollment.

Should my child be withdrawn for any reason prior to the end of the preschool year, I agree to submit to the director a written notice of withdrawal two weeks prior to the last day of attendance or agree to pay one additional month of full tuition.

No refunds will be given for withdrawal from the preschool prior to the end of the month or for days missed due to family vacations, illness, weather-related closings, or preschool breaks.

If serious difficulties should arise beyond the control of teachers or parents, which hinder a child from adapting to the classroom environment, New Vision Weekday Preschool is willing that he/she be withdrawn with a refund given for the balance of the tuition for the month.

Signature of Parent/Guardian: _____ Date: _____

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New Vision Weekday Preschool

The Tennessee Department of Human Services does not require that Preschools/Mother's Day Out/Parent's Day Out programs be licensed. Because of this exemption, this facility, New Vision Weekday Preschool is not a licensed child care facility.

Signature of Parent/Guardian: _____ Date: _____