

Belle Chasse Baptist Kindergarten
Enrollment Application

Please submit:

- Completed Enrollment Application
- Current Immunization Records
- Registration/Supply Fee

Please Print

Student Information

Student's Full Name: _____

Child's Preferred Name: _____ M _____ F _____

Date of Birth: _____ Age child will be 9/30/20 _____

Person with whom child lives: _____

Parent/Guardian Information 1

Name: _____ Relationship to Child: _____
Address: _____
Employer: _____
Cell Phone: _____ Work Phone: _____
E-Mail: _____

Parent/Guardian Information 2

Name: _____ Relationship to Child: _____
Address: _____
Employer: _____
Cell Phone: _____ Work Phone: _____
E-Mail: _____

Medical Information

Individuals to contact in case of an emergency:

_____	Phone #: _____
_____	Phone #: _____
_____	Phone #: _____
_____	Phone #: _____

Child's Doctor: _____ Doctor's Phone #: _____

Child's Dentist: _____ Dentist's Phone #: _____

- | | | |
|--|-----|----|
| Does your child have any food allergies? | Yes | No |
| Does your child have any other allergies? | Yes | No |
| Does your child have any dietary restrictions? | Yes | No |
| Does your child have any special needs? | Yes | No |
| Does your child have any health concerns? | Yes | No |

Please explain any "yes" answer here: _____

My child has permission to be released to the following individuals, in addition to emergency contact persons listed above.

(Please notify these individuals that they will be asked to show proof of identity).

Name (First and Last)	Relationship & Phone #

I authorize Belle Chasse Baptist Kindergarten to secure medical treatment for my child.

Parent's Signature: _____ Date: _____

