St. John the Baptist Catholic Church
Mother's Day Out
2020-2021 Registration Forms

A separate registration form is required for each child.
Registration fees must accompany registration forms.

Family Information

Child

Child's Full Name: ___________________________________ Preferred Name: ________________
Date of Birth: _________________ [ ] Male [ ] Female
Child's Home Address: ____
____ Zip Code: ________
Child's Home Phone Number: ____

Father: ______________________________ **Mother:** ______________________________
Status of Parents: [ ] Married [ ] Separated [ ] Divorced [ ] Other (please specify) _________
Occupation: __________________________ Occupation: ___________________________
Business Phone: _____________________ Business Phone: ________________________
Cell Phone: __________________________ Cell Phone: ____________________________

Preferred number to use if MDO needs to reach someone during our day:___________________

Family Information:

Email Address (required): ____
Family Church Affiliation: ____
Is child living with both parents? _____________ If NO, with whom? _____________________
Brothers and/or sisters: (indicate ages and if they live with the child):
_________________________________ _________________________________
_________________________________ _________________________________

Please list any other persons living with the child and their relationship to the child:
________________________________ _________________________________
________________________________ _________________________________

Pick-Up Information:

I give permission to release my child to parent/parents and the following persons:
1. ______________________________ 3. _________________________________
2. ______________________________ 4. _________________________________

Persons who may NOT pick up my child:
1. ______________________________
2. ______________________________ Signature: _____________________________

In Case of Emergency, list two (2) names OTHER THAN parents who we may contact:
1. ____ Phone: _________________________
2. ____ Phone: _________________________

Child's Name: ________________________

Health Care and History

Child's Physician: ______________________________________ Phone: _____________________

Check One: Is general health of child [ ] Good [ ] Fair [ ] Poor

List communicable diseases the child has had: ____

____

Please circle Yes, No or N/A for each of the following:

ALLERGIES - YES or NO

__ Food – list food(s): ____

__ Insect Sting – List insect(s): ____

__ Other (list): ____

____

Currently prescribed medications and treatments:

___ Oral antihistamine (Benadryl, etc.) __ Epi-pen __ Other _________________

ASTHMA – YES or NO

Triggers – Environmental (dust, pets, pollen, etc.) (list) ________________ Other (list) ________

Does your child experience asthma symptoms with exercise? ____ No ______ Yes

DIABETES – YES or NO

Currently prescribed medications and treatments:

___ Insulin ___ Syringe ___Pen ___Pump ___Blood Sugar Testing ___Glucagon

___Oral Medication(s) List Medication(s) ____

SEIZURE DISORDER – YES or NO

Describe: ____

SPECIAL DIET required – YES or NO

Describe: ____

OTHER HEALTH CONDITIONS – Included but not limited to: N/A

__ Anemia __ADD/ADHD __Cancer __Cerebral Palsy __Cystic Fibrosis __ Digestive Disorders

__ Emotional/Psychological __ Juvenile Rheumatoid Arthritis __ Hemophilia __Heart Condition

__ Physical Disability __ Skin Problems __ Irregular Bowels __Bladder Problems

__ Educational, social, emotional, or behavioral concerns __Other (explain) _________________

Mediation(s): ___ No ___Yes List Medication(s): _________________________________

SPEECH AND/OR LANGUAGE DELAY

Is your child currently receiving speech and/or language therapy services? Yes or No

Has your child previously received speech and/or language therapy services? Yes or No

Please describe the areas of concern: ____

____

____

Child's Name: ____________________

OTHER: Any other pertinent information we should know regarding your child's medical needs or that may require special attention. ____

____

____

***If you checked yes to any of the above, further medical information may be required. The director will let you know if additional information or documents are needed.*

Permission for Health Care

FIRST AID: In the event of an emergency, I authorize the staff to provide any first aid care deemed necessary.

Parent Signature: ______________________

EMERGENCY CARE: In the event of an emergency in which I cannot be reached, the physician listed above and the local hospital are hereby authorized to provide any emergency care deemed necessary for my child.

Parent Signature: ______________________

HEALTH RECORD TRANSFER: In the event of an emergency, I hereby authorize the transfer of child's health records to the local hospital.

Parent Signature: ______________________

I hereby authorize the staff of St. John the Baptist Catholic Church Mother's Day Out:

1. To care for my child during the time he or she is on our campus and in our care.
2. To secure emergency medical care for my child in the event that the staff is unable to reach me using the information provided.

Date: ________________ Signature: __________________________________

Child's Name: ______________________

Program Information, FEES, and Contractual Agreement

Registration fees must accompany the application. A separate application must be completed for each child being registered.

If for some reason we are unable to accommodate a class, your registration fee will be fully refunded.

MONTHLY TUITION

Parishioners

First Child	**Additional Child or Children in Family**
2 days/week - $165	2 days/week - $155
3 days/week - $230	3 days/week - $220

Non-Parishioners

First Child	**Additional Child or Children in Family**
2 days/week - $175	2 days/week - $165
3 days/week - $240	3 days/week - $230

Late Fees:
Tuition: Payment is due on the first of every month. Payment is considered late after five (5) days. Five to ten (5-10) days after tuition is due, a late fee of $25 will be added. Late payment after ten (10) days will result in termination of this contract. If you know that you will not be able to make a payment on time and still want your child to attend the Mother's Day Out program, please call and talk with Katie to make payment arrangements.

Withdraws: Two weeks advanced notice is required for withdrawal or payment of ½ month tuition.

Immunization Records: Current immunization records from your child's physician are due to the director prior to the first day of school.

I, ____________________________, contract to pay $_______.00 each month to St. John the
(Your Name Printed)
Baptist Mother's Day Out for the tuition for my child, and I understand the fee schedules.

Parent's Signature: _________________________________ **Date:** ____________

Pictures – Check Appropriate Blank

_____ I grant permission for St. John the Baptist Catholic Church and Mother's Day Out to use my child(ren's) name(s) and/or photograph(s) for use in St. John parish publications such as flyers, Facebook, the parish bulletin and the parish website.

_____ I do NOT want my child's photograph to be used by St. John the Baptist Catholic Church and Mother's Day Out.

Operating Fees, Schedule and Class Placement

Child's Name: ________________________ Sex: M or F DOB: __________

FEES:

A non-refundable Registration Fee of $150 is required at the time of registration for the first child. For each additional child, the Registration Fee is $100. **This fee is non-refundable.**

Signature: _______________________ Date: ___________

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DAYS REQUESTED Please review the following options and indicate your preference for your child. Please mark the option you would like your child to attend.

Please Choose One	# days/week	Days
	2	Tuesday/Thursday
	3	Tuesday-Thursday

Please note that class availability will be based on enrollment for the class.

CLASS PLACEMENT – Please check the appropriate class based on your child's DOB.

_________ **2 Year Old Class** **(must be 2 by 9/30/20)**
_________ **3 Year Old Class** **(must be 3 by 9/30/20)**
_________ **4 Year Old Class** **(must be 4 by 9/30/20)**

Contact Info:
Director: Katie Roettger
Phone Number: 225-955-2748
Email Address: MDO.StJohn@gmail.com