Bethel Christian Academy

A Quality Education in a Christian Environment

100 Park St. Canton, NC 28716

Contact us at (828) 648-4492

Bethel Christian Academy Pre-K Center

Enrollment Application

Application & Enrollment Date: _____

APPLICATION FOR BETHEL CHRISTIAN ACADEMY CHILDCARE

Name of child: _____ Birthdate: _____ Age: _____
(First) (Middle) (Last) (Mo/Day/Yr.)

Address: _____
(Street/P.O. Box) (City) (State) (Zip)

PARENTAL INFORMATION:

Father/Guardian Name: _____ Phone: (_____) _____-_____

Address: _____
(Street/P.O. Box) (City) (State) (Zip)

Employer: _____ Phone: (_____) _____-_____

Mother/Guardian Name: _____ Phone: (_____) _____-_____

Address: _____
(Street/P.O. Box) (City) (State) (Zip)

Employer: _____ Phone: (_____) _____-_____

CHILD'S INFORMATION:

Does your child have any allergies: (Food or Medication) (Circle No or Yes) NO YES

If YES, Please Explain: _____

Medications your child is taking: _____

_____

Please give any information concerning your child which will be helpful in his/her experience in the program:

_____

EMERGENCY INFORMATION:

Name of child's Doctor: _____ Facility: _____ Phone :(____) _____-_____

Name of child's Dentist: _____ Facility: _____ Phone :(____) _____-_____

If the Father or Mother cannot be contacted, please list the following that can make decisions on emergency care:

Emergency Contact #1: Name: _____ Phone :(____) _____-_____ Relationship: _____

Emergency Contact #1: Name: _____ Phone :(____) _____-_____ Relationship: _____

Hospital Preference (Circle One) HAYWOOD MISSION

If you cannot pick up your child, please list names of persons to whom your child can be released to:

1. _____ Relationship: _____ 2. _____ Relationship:_____
3. _____ Relationship: _____ 4. _____ Relationship:_____
5. _____ Relationship: _____ 6. _____ Relationship:_____

PLEASE NOTE: Above persons MUST bring a PHOTO ID to pick up your child. This is for safety reasons. Thank You!

Parent / Legal Guardian Signature: _____ Date: _____

I, the undersign director of the program agree to provide transportation to an appropriate medical resource in the event of an emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drugs or medications without specific instructions from the physician of the child's parents or legal guardian. Provisions will be made for adequate and appropriate rest and outdoor play.

Program Director's Signature: _____ Date: _____

Name of child: _____
(Last) (First) (Middle) (Nickname)

Child's Physical Address:

_____

(Street) (City) (State) (Zip)

FAMILY INFORMATION: Child lives with: _____

Father/Guardian Name: _____ Home Phone: (_____) _____-_____

Address (If different from child's): _____

(Street) (City) (State) (Zip)

Work Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Mother/Guardian Name: _____ Home Phone: (_____) _____-_____

Address (If different from child's): _____

(Street) (City) (State) (Zip)

Work Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

CONTACTS:

Child will be released only to the parents/guardians listed above. The child can also be released to the following individuals, as authorized by the person who signs this application. In the event of an emergency, if the parents/guardian cannot be reached, the facility has permission to contact the following individuals.

_____

Name	Relationship	Address	Phone Number

_____

Name	Relationship	Address	Phone Number

_____

Name	Relationship	Address	Phone Number

HEALTH CARE NEEDS:

For any child with health care needs such as allergies, asthma, or other conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child's parent or health care professional. Is there a medical action plan attached? Yes_____ No _____

List any allergies and the symptoms and type of response required for allergic reactions: _____

_____

_____

List any health care needs or concerns, symptoms of and types of response for these health care needs or concerns: _____

_____

_____

List any particular fears or unique behavior characteristics the child has: _____

_____

_____

List any types of medication taken for health care needs: _____

Share any other information that has a direct bearing on assuring safe medical treatment for your child: _____

_____

EMERGENCY MEDICAL CARE INFORMATION:

Name of health care professional: _____ Office Phone :(____) _____-_____

Hospital Preference: _____ Phone :(____) _____-_____

I, as the parent/guardian, authorize the center to obtain medical attention for my child in an emergency.

Parent / Legal Guardian Signature: _____ Date: _____

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of an emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or medication without specific instructions from the physician or the child's parents, guardian, or full-time custodian.

Signature of Administrator: _____ Date: _____

BETHEL CHRISTIAN ACADEMY

REGISTRATION AGREEMENT

STUDENT'S NAME: _____

STUDENT'S BIRTHDAY: _____

Date of enrollment: _____

PAYMENT FREQUENCY:

I have chosen to pay….

_____ Weekly _____ Bi-Weekly _____ Monthly

OTHER:

_____ I am aware of the Late Pick-Up Policy and agree to follow it.

PERMISSIONS:

_____ I give permission for my child to play outside of the fenced in area.

_____ I give permission for my child to be photographed at BCA.

_____ I give permission for BCA to post photos of my child on Facebook or use photos of my child for advertisement of other purposes.

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____