DISCIPLES
Child Development Center

INFANT REGISTRATION FORM

OFFICE USE ONLY
$100 NON-REFUNDABLE Registration Fee

Date Received: _____

Registration Fee Received: ☐ Yes No

Amount Received: Check #: _____

Amount Due: _____

Days Chosen: (circle) MON TUE WED THUR FRI

Class/Teacher: _____

MALE OR FEMALE (circle)

Child's Name: _____

Child's Birthdate: _____

Home Address: _____

_____

Home Phone Number: _____

Email Address: _____

Mother's Name: _____ Mother's Cell Number: _____

Occupation: _____

Place of Employment: _____

Phone Number: _____

Father's Name: _____ Father's Cell Number: _____

Occupation: _____

Place of Employment: _____

Phone Number: _____

Child's Physician: _____ Phone Number of Physician: _____

Any known allergies? _____

Has your child ever had a fever-induced seizure? If so, please explain. _____

_____

Relative or close friend in case of emergency: _____ Phone Number: _____

Please list any information or special instructions that you feel would be helpful to us regarding your child:

_____

A $100 NON-REFUNDABLE registration fee must accompany this form to secure a spot for your child.
An updated immunization form must be presented by the first day of school.