

St. John the Baptist Catholic Church
Mother's Day Out
2024-2025 Registration Form

A separate registration form is required for each child.
Registration fee(s) must accompany registration forms.

Family Information

Child's Full Name: _____ Preferred Name: _____

Date of Birth: _____ Male Female

Child's Home Address: _____
_____ Zip Code: _____

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

Parent Signature

In Case of Emergency, list two (2) names OTHER THAN parents who we may contact:

1. _____ Phone: _____
2. _____ Phone: _____

Health Care and History

Child's Physician: _____ Phone: _____

Check One: Is general health of child Good Fair Poor

Please check the appropriate box for each of the following:

Allergies - YES 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 NO

Triggers – Environmental (dust, pets, pollen, etc) (list) _____ Other (list) _____

Does your child experience asthma symptoms with exercise? Yes No

Describe and Treatment _____

DIABETES - YES NO

Currently prescribed medications and treatments:

Insulin Syringe Pen Pump Blood Sugar Testing Glucagon

Oral Medication(s) list medications _____

SEIZURE DISORDER - YES NO

Describe: _____

SPECIAL DIET required - YES NO

Describe: _____

OTHER HEALTH CONDITIONS – Included but not limited to:

Anemia	Emotional/Psychological	Skin Problems
ADD/ADHD	Juvenile Rheumatoid	Irregular Bowels
Cancer	Arthritis	Bladder Problems
Cerebral Palsy	Hemophilia	Educational, social,
Cystic Fibrosis	Heart Condition	emotional or
Digestive Disorders	Physical Disability	behavioral concerns
Other (explain): _____		

Medication(s): Yes No If yes, list medication(s): _____

SPEECH AND/OR LANGUAGE DELAY

Is your child currently receiving speech and/or language therapy services? Yes No
Has your child previously received speech and/or language therapy services? Yes No
Please describe the areas of concern: _____

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 and preferred hospital, _____, if applicable, 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 my 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.

Parent Signature: _____ **Date:** _____

Program Information

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 Lil to make payment arrangements.

Withdraws: Two weeks advance 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
Your Name Printed

St. John the Baptist Mother's Day Out for the tuition for my child and I understand the fee schedules.

Parent Signature: _____ **Date:** _____

Pictures

Check Appropriate Box

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 the Baptist 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 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.**

Supply Fee(s) are due at the beginning of the MDO year: \$50 1-3 yr olds, \$60 4 yr old

Parent Signature: _____ Date: _____

MONTHLY TUITION:

Parishioners:

First Child

2 days/week - \$175 per month
 3 days/week - \$240 per month

Additional Child or Children in Family

2 days/week - \$165 per month
 3 days/week - \$230 per month

Non-Parishioners:

First Child

2 days/week - \$185 per month
 3 days/week - \$250 per month

Additional Child or Children in Family

2 days/week - \$175 per month
 3 days/week - \$240 per month

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
<input type="checkbox"/>	2	Tuesday/Thursday
<input type="checkbox"/>	3	Tuesday-Thursday

*Please note that class availability will be based on enrollment for the class.
 *Enrollment fees will be voided, if class is not formed

CLASS PLACEMENT – Class placement will be determined by your child's birthday and other educational factors. Program ages: 18 months (must be 18 months by 9/30/24) - 4 Year Old Class (3 days only)

Child's DOB: _____

Contact Info:

Director: Lilith Stutes
 Phone Number: 225-413-4527
 Email Address: MDO.StJohn@gmail.com