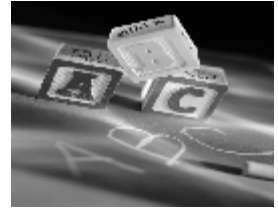


ENROLLMENT FORM

Alexander's Bible-Centered Preschool

4316 Pamela Court, Chesapeake, Virginia 23321 757-405-5572
Jill Willoughby, School Administrator



Child's Name _____ Birthdate _____ Sex _____

Parents' Relationship to Each Other: Married Divorced Separated Single

Child lives with (please check all that apply:

Mother and Father Mother Father Other _____

Father's Name _____ Driver's License _____

Home Address _____ Phone _____

City _____ State _____ Zip _____ E-Mail: _____

Occupation _____ Employer _____

Work Phone _____ Pager _____ Cell Phone _____

Mother's Name _____ Driver's License _____

Home Address _____ Phone _____

City _____ State _____ Zip _____ E-Mail _____

Occupation _____ Employer _____

Work Phone _____ Pager _____ Cell Phone _____

Family Religious preference _____ Church membership _____

How did you find out about our program? _____

List at least one local person who will be available to assume responsibility for your child in an emergency if parents cannot be reached.

Name _____ Relationship to child _____

Address _____ Driver's License _____

City _____ State _____ Zip _____

Occupation _____ Employer _____

Work Phone _____ Pager _____ Cell Phone _____

Release of Child

I authorize that my child, _____, be released by Alexander's Bible-Centered Preschool to the following persons, in addition to those already listed on page one of this form.

Name _____ Relationship to child _____
Address _____ City _____ State _____ Zip _____
Work phone _____ Home phone _____ Cell phone _____

Name _____ Relationship to child _____
Address _____ City _____ State _____ Zip _____
Work phone _____ Home phone _____ Cell phone _____

Emergency Medical Care

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize Alexander's Bible-Centered Preschool staff to take my child to an Emergency Room, or to the following physician or his/her associates, for medical care.

Preferred Hospital (if possible) _____

Dr. _____

Address _____ Phone _____

City _____ State _____ Zip _____

I give consent for any and all treatment necessary by the attending physician.

(Please attach a photocopy of your insurance card.)

Signature of Parent/Guardian

State of _____ **City/County of** _____

This instrument was acknowledged before me on (date) _____ by _____

(Notary Seal)

Signature of Notary Public

For Office Use Only

Date of Interview _____ Interviewed by _____

Date of Enrollment _____ Class Assignment _____