



# APPLICATION FOR ADMISSION

Circle One: 2 Day \_\_\_\_\_ 3 Day \_\_\_\_\_

*An application/supply fee of \$50 must accompany this form in order to hold the child's place. The deposit will be refunded if classes close prior to receipt.*

Child's Name \_\_\_\_\_ Gender \_\_\_\_\_

Birthdate \_\_\_\_\_ Exact Age as of Sept 1 \_\_\_\_\_

Home Address \_\_\_\_\_  
Street or PO Box City State Zip

Phone: \_\_\_\_\_ In Foster Care: Yes or No  
Main

**Mother's Name:** \_\_\_\_\_ **Day Phone:** \_\_\_\_\_

Address (if different from child) \_\_\_\_\_  
Street or PO Box City State Zip

Email \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ **Day Phone:** \_\_\_\_\_

Address (if different from child) \_\_\_\_\_  
Street or PO Box City State Zip

Email \_\_\_\_\_

**Emergency Contact** (in case either parent cannot be reached):

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Has your child previously attended a weekday ministry or program? \_\_\_\_\_

Where? \_\_\_\_\_

How did you discover TABERNACLE WEEKDAY? \_\_\_\_\_

Religious Affiliation \_\_\_\_\_ Church attending \_\_\_\_\_

*Each child must have a doctor's certificate stating that the child is free from any communicable disease, that the immunizations are up to date, and restrictions of activity, if any. The attached report may be used, or a certificate from the doctor's office, but MUST be signed by the examining physician.*

*Also attach up to date immunization record per child or immunization exemption.*

## Health Form

*This form is to be completed each school year and as updates are needed. A Physician's signature is required.*

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Physician's Name \_\_\_\_\_ Office Phone \_\_\_\_\_

Has the student had or does the student have any of the following? If so, please explain.

<input type="checkbox"/> Allergies	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Serious Illness
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hernia	<input type="checkbox"/> Serious Accident
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Visual Disorder
<input type="checkbox"/> Emotional Disorder	<input type="checkbox"/> Orthopedic Disorder	<input type="checkbox"/> Other

Explanation \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### PHYSICIAN TO COMPLETE AND SIGN:

Is this child free of infection and contagious disease?  Yes  No

Is this child to physically and mentally able to engage in age-appropriate group activities?  Yes  No

Does this child have any allergies? Please list \_\_\_\_\_

\_\_\_\_\_

Is there any other information that our ministry should know regarding this student's health?

Yes  No Explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

## Parent Permission/Consent

Child's Name \_\_\_\_\_

Please initial for each of the following with which you AGREE. If you do NOT agree, leave blank.

\_\_\_\_ I authorize TABERNACLE WEEKDAY to **release my child/children ONLY** to the following individuals. I will notify the ministry when changes may be necessary.

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_ In the event that I cannot be reached in an emergency, I authorize and give my **consent** to TABERNACLE WEEKDAY (or Tabernacle Baptist Church) staff for any and all necessary **emergency medical treatment** for my child.

\_\_\_\_ I **release** TABERNACLE WEEKDAY and Tabernacle Baptist Church or any of it's volunteers from any **liability** regarding **injury** to my child that may occur **accidentally**.

\_\_\_\_ I give my permission to **include** my child's name, my name, address and phone number to be published on a **class roster** ONLY for classroom and personal use-not for solicitation purposes.

\_\_\_\_ I recognize that I am responsible to read, and abide by, the policies of the TABERNACLE WEEKDAY **Handbook**.

\_\_\_\_ I also understand that **failure to abide** by the policies and procedures may result in my child or children being dismissed from the TABERNACLE WEEKDAY ministry.

\_\_\_\_ I give my consent to Tabernacle Baptist Church to take **photographs and/or video** of my child, waive any claims against Tabernacle Baptist Church arising from or related to such media, and waive and/or assign all rights (including copyright) in such media to Tabernacle Baptist Church. Tabernacle Baptist Church, as the sole owners of such media, shall have the exclusive right to control and determine the use, display, performance, reproduction and dissemination of such photographs, video or media. I also agree to allow such photos and videos of myself and/or my child to be **published via print, video or website** affiliated with Tabernacle Baptist Church or its related entities.

\_\_\_\_ I understand that **publication** of photographs and/or videos may be accomplished electronically via the Internet/Worldwide Web, and that after publication, Tabernacle Baptist Church will be unable to prevent persons from gaining access to the Internet/Worldwide Web, copying such photographs and video, and subsequently using, altering or republishing them without my consent. As such, I also specifically **waive any claim for damages** against Tabernacle Baptist Church for the **unconsented use, alteration or republication of the photographs and videos by third parties** access the Internet/Worldwide Web or obtaining copies of the print or video material.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_