

**For Office use only:**

Date received \_\_\_\_\_

Received by \_\_\_\_\_

Cash amt. \_\_\_\_\_

Check amt. \_\_\_\_\_

## FBC Preschool Enrollment Application 2026 - 2027 School Year

**An \$80.00 non-refundable registration fee is due at the time of registration.**

Day(s) you are requesting for enrollment (please circle)      M      TU      W      TH

Class you are requesting for enrollment (please circle)      Two's      Three's      Four's

Child's name \_\_\_\_\_  
Last First Middle Preferred Name

Birth date \_\_\_\_\_ Age as of 8/31/26 \_\_\_\_\_  
Mo. Day Year

**(please circle) Male or Female**

Address \_\_\_\_\_  
Street Town Zip

Home phone \_\_\_\_\_ Marital status of parents \_\_\_\_\_

**Preferred phone number to call during preschool hours** \_\_\_\_\_

E-Mail address \_\_\_\_\_

Father's name \_\_\_\_\_ Home phone (if different) \_\_\_\_\_

Home address (if different) \_\_\_\_\_  
Street Town Zip

Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Business phone \_\_\_\_\_

Cell phone or pager \_\_\_\_\_

Mother's name \_\_\_\_\_ Home phone (if different) \_\_\_\_\_

Home address (if different) \_\_\_\_\_  
Street Town Zip

Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Business phone \_\_\_\_\_

Cell phone or pager \_\_\_\_\_

Is your family presently members of a local church, and if so which one? \_\_\_\_\_

**Medical Attention Permission Form:**

In the event of an emergency, I hereby authorize the personnel of FBC Preschool to seek medical attention and treatment for my child, \_\_\_\_\_.

\_\_\_\_\_  
Parent/Guardian Signature

**FBC Preschool: Child's Confidential Record**

Please fill out the information below so our teachers may have a better understanding of your child and your child's individual needs. Thank you.

Siblings who are also enrolled at FBC Preschool:

Name: \_\_\_\_\_ Age \_\_\_\_\_

Name: \_\_\_\_\_ Age \_\_\_\_\_

Name: \_\_\_\_\_ Age \_\_\_\_\_

Group experiences:

☐ Center based child-care

☐ Church Sunday School

☐ Other \_\_\_\_\_

☐ Parent's Morning Out/Preschool

☐ Home based child care

Name of child's doctor: \_\_\_\_\_

Office number: \_\_\_\_\_ Address: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

Please list any food or environmental allergies your child has, and the reaction: \_\_\_\_\_

