



**FAITH BAPTIST ACADEMY**

301 Bill Foster Memorial Hwy, Cabot, AR 72023  
501-843-1055 [www.fba.faithcabot.org](http://www.fba.faithcabot.org)

**INFANT • TODDLER • PRESCHOOL • PRE-KINDERGARTEN  
REGISTRATION FORM**

DATE: \_\_\_\_\_

Child's Name: \_\_\_\_\_ M \_\_\_ F \_\_\_ Date of Birth \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name \_\_\_\_\_

Legal Guardian's Name: \_\_\_\_\_

Parents' Marital Status \_\_\_\_\_ Legal Custody Papers: Y / N (If yes, attach a copy)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Cell Phone \_\_\_\_\_

Mother's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Father's Cell Phone \_\_\_\_\_

Father's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Email address, used for monthly statements \_\_\_\_\_

**FBA SCHEDULE**

Full-Time \_\_\_\_\_ Tues / Thurs \_\_\_\_\_ Mon / Wed / Fri \_\_\_\_\_

**FOR FBA OFFICE USE ONLY**

WEEKLY TUITION \_\_\_\_\_

START DATE \_\_\_\_\_

DATE REG. PAID \_\_\_\_\_

IMMUNIZATION REC \_\_\_\_\_ BIRTH CERTIF \_\_\_\_\_

CLASS ASSIGNMENT \_\_\_\_\_

ADMIN \_\_\_\_\_

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**PARENTAL POLICY AGREEMENT**

I have read the **Faith Baptist Academy Parent Handbook**. I understand and agree to all the policies, including those regarding payment of fees, general procedures and guidance for learning in all developmental areas.

I grant permission to Faith Baptist Church and to its employees, the right to photograph my child and use the photo and or other digital reproduction of him/her or other reproduction of his/her physical likeness for publication processes, whether electronic, print or digital publishing via the Internet. Your child’s name will not be included with the photo.

SIGNATURE OF PARENT (S) OR LEGAL GUARGIAN (S)

\_\_\_\_\_ DATE \_\_\_\_\_

\_\_\_\_\_ DATE \_\_\_\_\_

**For parents of children aged two and under:**

I have received information published by the Arkansas Department of Health on prevention of Shaken Baby Syndrome in accordance with Carter’s Law, Act 1208 of 2013.

<http://www.healthy.arkansas.gov/programsServices/familyHealth/ChildAndAdolescentHealth/Documents/ShakenBabyBrochureEnglish.pdf>

SIGNATURE OF PARENT (S) OR LEGAL GUARGIAN (S)

\_\_\_\_\_ DATE \_\_\_\_\_

\_\_\_\_\_ DATE \_\_\_\_\_

Empty rectangular box for additional notes or signatures.

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## EMERGENCY CONTACT INFORMATION

A COPY OF THIS FORM WILL ACCOMPANY YOUR CHILD IN THE CASE OF BEING TRANSPORTED FROM FBA FOR EMERGENCY PURPOSES

Name of Child: \_\_\_\_\_

Parents' Names & Contact Numbers:

Mother \_\_\_\_\_ Phone Numbers: \_\_\_\_\_

Father \_\_\_\_\_ Phone Numbers: \_\_\_\_\_

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Contact, if parents cannot be reached:

Name: \_\_\_\_\_ Relation to child \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

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Physician's Name: \_\_\_\_\_ Phone number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

My child has these known allergies to the following medications: \_\_\_\_\_

My child has these known food allergies: \_\_\_\_\_

### CONSENT FOR EMERGENCY MEDICAL CARE / TRANSPORTATION AUTHORIZATION

I \_\_\_\_\_ the Parent/Legal Guardian of \_\_\_\_\_ do hereby request and give consent to the Director of Faith Baptist Academy, or his/her duly appointed representative, for said child to receive such medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician in case of an emergency when parents cannot be reached. Consent is also given for the Director or his/her duly appointed representative to transport said child for emergency medical treatment if the parents cannot be reached. I will be responsible for the physician and/or hospital fees.

Witness \_\_\_\_\_ Parent/Guardian \_\_\_\_\_

Date

Date

**ADDITIONAL ADULTS AUTHORIZED TO CHECK OUT MY CHILD**

**NAME(S)** \_\_\_\_\_ **RELATION TO MY CHILD** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_

**PHONE 1:** \_\_\_\_\_ **TYPE:** \_\_\_\_\_ / **PHONE 2:** \_\_\_\_\_ **TYPE:** \_\_\_\_\_

**NAME(S)** \_\_\_\_\_ **RELATION TO MY CHILD** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_

**PHONE 1:** \_\_\_\_\_ **TYPE:** \_\_\_\_\_ / **PHONE 2:** \_\_\_\_\_ **TYPE:** \_\_\_\_\_

**SECURITY PASSWORD:** \_\_\_\_\_ This password is required when you call authorizing an additional adult to pick up your child.

\* Inform and provide FBA office staff of legal custodial matters concerning your child. At the time your child has been checked out of the center by you or an authorized adult, FBA personnel are no longer responsible or liable for your child's injury.

**PARENT/ LEGAL GUARDIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**GENERAL INFORMATION**

Check those that apply:

- Right Handed                       Left Handed                       Independent in Restroom
- Needs Help in Restroom               Attempting Toilet Training

**Physical or Emotional Considerations:** \_\_\_\_\_

**Developmental Diagnosis:** \_\_\_\_\_

**Food Allergies:** \_\_\_\_\_

**MEDICAL HISTORY**

**Current medications taken and dosage** \_\_\_\_\_

- Asthma     Diabetes     Seasonal Allergies     Other Diagnosis \_\_\_\_\_

**Frequent Infections:**

- Ear                       Throat                       Other \_\_\_\_\_

**Authorization for Acetaminophen (Tylenol)**     YES                       NO

**Authorization for Ibuprofen (Motrin)**               YES                       NO

\*FBA cannot exceed recommendation prescribed on packaging; weight & age will indicate appropriate dosage.

