Beverly Hills Preschool

Beverly Hills Baptist Church
Weekday Early Education Program
Enrollment Form

Child's Name:_____ Goes by:_____

_____ Male _____ Female / Age _____ Date of Birth ____/____/____

Address:_____ City:_____ State:_____ Zip:_____

Phone: (Home) _____ Cell: _____

E-Mail Address:_____

What is the best way to contact you? _____ Home _____ Cell _____ E-Mail

Mother's Name:_____ Occupation_____

Employer:_____ Business Phone:_____

Father's Name:_____ Occupation_____

Employer:_____ Business Phone:_____

Marital Status: _____ Married _____ Separated _____Divorced _____Single

Other children in the home:

Name_____ Date of Birth _____

Name_____ Date of Birth _____

Name_____ Date of Birth _____

Church Affiliation:_____

Emergency Contacts other than parents. (Also authorized to pick up my child in my absence.)

Emergency Contact 1_____Phone Number:_____

Emergency Contact 1_____Phone Number:_____

Days of attendance: ____M ____T ____W ____T ____F _____ 4 hr _____3 hr

How did you hear about BHBC Preschool:_____

IMPORTANT INFORMATION:

Your child is not considered enrolled until registration is paid.

The registration fee is NON-REFUNDABLE

FOR CENTER USE ONLY

Registration Fee Paid $ _____ Date:_____ Cash_____ Check # _____

Class Assignment _____ Teacher_____

Forms Received: Health: _____ Handbook/Picture permission: _____ Emergency Card:_____

COVID-19 Waiver _____

FORM 2: PHYSICAL EXAMINATION
(TO BE COMPLETED BY PHYSICIAN)

Child's Name _____ Date of Birth _____

Parent's or Guardian's Name _____

Address _____ Telephone No. _____

Height _____ Weight _____

Skin _____ Head & Scalp _____

Eyes _____ Nose _____ Lymph Nodes _____

Ears _____ (L) TM _____ (R) TM _____

Mouth: Teeth _____ Gingiva _____ Palate _____

Throat _____ Neck _____ Chest _____

Heart _____ B.P. _____ Femoral Pulse _____

Lungs _____ Abdomen _____

Genitalia _____ Rectum, anus _____

Spine and back _____ Extremities _____

Neuromuscular _____ Gait _____

Urinalysis _____

Vision: (R) Eye _____ (L) Eye _____ Both _____

Hearing: Normal _____ Abnormal _____ Not tested _____

Allergies _____

By This Age:	Children Need These Shots:						
3 months		1 Hep B					
5 months		2 Hep B			2 Polio		
7 months	3 DTaP	2 Hep B	2-3 Hib		2 Polio	3 PCV	
12 months	3 DTaP	2 Hep B	2-3 Hib		2 Polio	3 PCV	
16 months	3 DTaP	2 Hep B	3-4 Hib	1 MMR	2 Polio	4 PCV	
19 months	4 DTaP	3 Hep B	3-4 Hib	1 MMR	3 Polio	4 PCV	1 Var
4 years or older (in child care only)	4 DTaP	3 Hep B	3-4 Hib	1 MMR	3 Polio	4 PCV	1 Var
4 years and older (and in kindergarten)	5 DTaP	3 Hep B	3-4 Hib	2 MMR	4 Polio	4 PCV	2 Var

Immunizations are up to date for age of child: yes _____ no _____

I examined this child on (date) _____. I find him/her to be in good physical condition, free of contagious and infectious diseases, and capable of participating in preschool activities except as noted below.

_____

_____

_____ _____

Date Physician's signature