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_____ **Phone Number**_____

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	3-4 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 Hiv	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	2 Polio	4 PCV	2 Var

Immunization 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 infections diseases, and capable of participating in preschool activities except as noted below.

_____

_____

_____ _____

Date **Physician's Signature**