

CHILD INFORMATION FORM
FIRST STEPS PRESCHOOL – RIVER BEND BAPTIST CHURCH

(This is for your child's teacher in order to better serve your child.)

Please put an "x" by each phrase that applies to your child.

CHILD'S NAME _____ NAME USED _____ SEX _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

BIRTHDATE _____ AGE AS OF SEPTEMBER 1 OF SCHOOL YEAR _____

FATHER'S NAME _____ MOTHER'S NAME _____

EMAIL ADDRESS _____ MAILING ADDRESS _____

HOME PHONE NUMBER _____ CELLPHONE NUMBER _____

SIBLINGS AND AGES _____

Would you like your address released to other parents for things like birthday party invitation? YES or NO

My child has:

_____ Allergies: please list _____

_____ Been hospitalized in the last 12 months for _____

_____ This existing/previous serious injury or illness _____

_____ To take this long-term medication _____ For _____

_____ Hearing loss/difficulties _____

_____ Vision difficulties _____

_____ Speech difficulties _____

_____ Special time with a counselor/therapist to help with _____

Social Development and Play Habits

My child:

_____ Feels comfortable talking to adults other than his/her parents

My student responds best with this kind of encouragement/love language _____

_____ Has/Has not (Circle one) been in preschool for _____ years

_____ Has trouble separating from parents. Comments _____

_____ Plays regularly with children whose ages are _____

_____ Plays well with others _____ does not like to play with others _____ Is Shy _____ Is Outgoing

Favorite play activity _____

Toileting Habits

My child:

_____ Is in diapers _____ Is in training _____ Is independent in using the toilet.

(3's and 4's must be independent in using the toilet)

Uses the word _____ for needing to use the toilet.

Favorite Book _____

Fears _____

Sleeping Habits

My child:

_____ Usually takes a nap at _____ a.m./p.m.

_____ Does not typically nap

_____ Likes to go to sleep with _____ (bottle, pacifier, blanket, etc.)

Eating Habits

My child:

_____ Has a healthy appetite _____ usually is not very hungry

_____ Is on a special diet of _____

(Parents may need to provide all snacks in this situation).

My child is **left-handed/right-handed** (circle one)

My child speaks the following language(s) _____

Unique or unusual family situation that the teacher should know _____

Write additional comments on the back of the page.

FIRST STEPS PRESCHOOL
River Bend Baptist Church
27600 FM 1093
Fulshear, TX 77441 281-346-2279

FOR OFFICE USE ONLY

Date received _____
Starting date _____
Class _____
Registration Fee: _____

REGISTRATION FORM

Child's Full Name _____ Nickname _____

Mailing Address _____

Street _____ city _____ zip _____

Sex _____ Child's Birthdate _____ Home Phone# _____

Month _____ Day _____ Year _____

Child's Age as of September 1, 2024 _____

Mother's Name _____

Driver's License # and State _____ Cell # _____

Email address _____

Employer _____

Father's name _____

Driver's License # and State _____ Cell # _____

Email Address _____

Employer _____ Work# _____

Names and ages of siblings:

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

We are members of River Bend Baptist Church (for tuition purposes) _____ Yes _____ No

DISMISSAL INFORMATION (Driver's License or picture ID and Phone # are required before a child will be released to those

listed.)

NAME

DRIVER'S LICENSE # AND STATE

PHONE #

I understand that this child will not be released from FSP to anyone other than the parents unless named above or named as an Emergency Contact. Names may be added or deleted at any time. This change must be given to the FSP office or child's teacher IN WRITING. This would include carpools.

Parent's Signature _____

FSP Reg. Form

JAN 2024

FINANCIAL AGREEMENT
(Financial Terms and Conditions)
FIRST STEPS PRESCHOOL –RIVER BEND BAPTIST CHURCH

Please initial each statement to acknowledge acceptance of terms.

_____ The registration/supply fee is required to secure a place for my child at FSP. This fee is non-refundable.

_____ The monthly tuition fees are NON-REFUNDABLE. If tuition is prepaid by the semester or year, a refund will be given with thirty (30) days notice of intent to withdraw the child.

_____ September 2024 tuition is due by September 4, 2023.

_____ I will prepay May 2025 tuition. This full-month payment is due by September 4, 2024. This fee is typically NON-REFUNDABLE with the following exception. Before March 1, it will be applied to the last month's tuition with a thirty-day written notice. (Example--If written withdrawal notice is given February 28 to withdraw the end of March, the prepaid May tuition will cover the March tuition. If written withdrawal notice is given March 30 to withdraw the end of April, the prepaid May tuition will not cover the April tuition.)

_____ Full tuition is due each month regardless of absences, holidays, and other school closings. FSP will follow the Lamar CISD/Katy ISD calendars with the exception of the first and last days of school.

_____ There are no "make-ups" for missed days.

_____ The tuition is due on the first class day of each month. Tuition not paid by the 15th day of the month will incur a \$10 late fee.

_____ Returned checks will result in a \$20 assessment on my child's account.

_____ Children not picked up by 2:25 p.m. will be left in the Director's care. The child's account will be assessed the late pick-up fee as defined by the Parent Handbook.

_____ Current tuition must be paid in full to register for the next school year. If current tuition is not paid in full at the time of registration for the next school year, my child will not be allowed to register.

_____ If my tuition becomes two months in arrears, my child may be dropped from the program.

I agree to the financial terms listed above.

Child's Name: _____

Parent's Name (Please Print)

Parent's Signature

Date _____

FIRST STEPS PRESCHOOL – RIVER BEND BAPTIST CHURCH
HEALTH STATEMENT

CHILD'S NAME _____ Date of birth _____
Month/day/year

MEDICAL HISTORY: Please indicate yes or no for every question.

My child has had: measles yes/no mumps yes/no chicken pox yes/no
 meningitis yes/no convulsions yes/no

List any allergies (including foods)

Has child been hospitalized in the last 12 months? Yes/no Explain _____

List all long-term medications _____

Is there evidence of: hearing loss or difficulties yes/no vision difficulties yes/no
 speech disabilities yes/no

My child is in: Speech yes/no Other Programs _____

My child has other special needs or information helpful to the teachers. Yes/no

This section to be completed by physician.

Physician's name _____ Phone # _____

Address _____

Child's Name _____ has been examined by me, and I have found him/her to be free of communicable diseases and is physically able to participate in a preschool program.

PHYSICIAN'S SIGNATURE (office stamp) _____ **DATE** _____

IMMUNIZATIONS: Please record dates below or attach a copy. Refer to immun. schedule for state requirements.

	BIRTH	2MONTHS	4MONTHS	6MONTHS	12MONTHS	15MONTHS	24MONTHS	4-6YEARS
HEP-B								
DTaP								
Polio/IPV								
Hib								
Pneumococcal Prevnar/PCV7								
MMR								
Varicella Chicken Pox								
HEP-A	DOSE	1	DOSE	2				
TB Test Date (Recommended)		(circle one)	Positive	Negative				

HEARING AND VISION SCREENS are required for children four years old by Sept. 1 and children 5 years by Sept. 1 who are not in public school. Please attach results. If done by your doctor it must be done between June 1, 2023 and August 2024

EMERGENCY MEDICAL INFORMATION AND RELEASE FORM

A Copy of this form accompanies your child on any FSP Field Trips.

CHILD'S NAME _____ BIRTHDATE ____/____/____
Month Day Year

PARENT'S NAMES _____

HOME ADDRESS _____
Street city zip

HOME PHONE # _____ FATHER'S WORK # _____ CELL # _____
MOTHER'S WORK # _____ CELL # _____

CHILD'S ALLERGIES _____

OTHER HEALTH PROBLEMS _____

DOCTOR'S NAME _____ PHONE # _____

DOCTOR'S ADDRESS _____

HEALTH INSURANCE NAME _____

HEALTH INSURANCE PHONE # _____ POLICY # _____

LIST TWO OTHER PERSONS TO CONTACT IN CASE OF EMERGENCY:

1. NAME _____ RELATIONSHIP _____
PHONE # _____
ADDRESS _____
Street city zip
2. NAME _____ RELATIONSHIP _____
PHONE # _____
ADDRESS _____
Street city zip

MUST BE NOTARIZED

Parental consent is a legal requirement for treatment of a minor child. To authorize emergency treatment of your child in the event you are unable to be contacted, the following affidavit must be signed in the presence of a notary and properly notarized.

I, (print name) _____, parent/legal guardian, hereby authorize a FSP Staff Member to consent to medical treatment of my child, _____, when I cannot be contacted. Such consent includes, without limitation, x-rays, injections, anesthetic, medical, dental, or surgical examinations or treatment, and or hospital care. No prior determination of life threatening emergency or danger of treatment needs to be made under this Authorization."

This authorization remains effective until May 31, 2021.

Sign in the presence of notary -- parent/legal guardian signature

date

STATE OF TEXAS County of _____

This instrument was acknowledged before me by _____

on this the _____ day of _____ 20 _____

Commission expires _____

Notary Signature _____