



1510 Greenville Blvd, SE
Greenville, NC 27858
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Memorial Baptist Preschool

2024-2025 REGISTRATION FORM

Tots ___ MW (\$150) ___ TTH (\$150) *15 months by 8/31/24*
2 Year ___ TTH (\$150) ___ MWF2(\$210) ___ M-Th(\$280)
3 Year ___ MWF (\$180) ___ M-F (\$290)
PreK ___ M-Th(\$225) ___ M-F (\$250)

*Class eligibility is determined by birthdate as of 8/31/24.
Registration fee in amount above will be billed via Brightwheel
when you register.*

Classes may be adjusted based on demand. Enrollment will be confirmed after registration fee has been paid.

Name of Child _____ Birthdate _____

Preferred Name _____ Present age _____ Gender _____

Address _____ Zip _____

Mom's Cell Phone _____ Dad's Cell Phone _____

Father's Name _____ Occupation _____

Employer _____ Work phone _____

Mother's Name _____ Occupation _____

Employer _____ Work phone _____

Parents Relationship to Each Other: Married _____ Divorced _____ Separated _____ Single _____

Child lives with (check those that apply): Both Parents _____ Father _____ Mother _____

Other children in family (list names, ages, and gender):

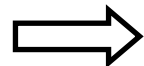
Previous program attended _____

Local church you attend _____ Does child attend Sunday School? _____

Would you like to receive emails from The Memorial Baptist Church regarding church activities and happenings?

Yes _____ No _____ If yes, email address _____

PLEASE TURN OVER AND COMPLETE THE BACK



For Office Use:

Student Entered in Brightwheel _____ Reg Fee Billed _____ Reg Fee Paid _____

BW Data Complete _____ BW Billing Plan 24-25 _____ Class Assigned _____

Please share any additional information about your child that you think would be helpful to the teacher (likes or dislikes, etc.):

Does child have any known allergies? _____ If yes, please list _____

Does child have asthma? _____

Does, your child have any speech, language, hearing, or other needs? _____ Yes _____ No

If so, what are they? _____

Is your child taking any medication at the present time? _____ If so, name and purpose of medication _____

Emergency Medical Care

Child's Doctor _____ Phone: _____

Address _____ City _____ Zip _____

Child's Dentist _____ Phone _____

Insurance Company Name _____

Policy Number _____

If emergency medical care becomes necessary, I give permission for my child to receive such treatment as required by the physician.

Parent's Signature

In case of emergency, list one local person who will be available to assume responsibility if neither mother nor father can be reached.

Name _____ Relationship to child _____

Home Phone _____ Cell Phone _____ Work Phone _____

I hereby agree to follow the Preschool Program rules and policies. I will work with the Preschool staff to resolve any issues or concerns that may arise. I understand the **registration fee is non-refundable and non-transferable upon receipt of payment and no exceptions will be made.**

Parent's Signature