CHURCH OF THE HOLY SPIRIT
MOTHERS' DAY OUT

2026-2027 REGISTRATION FORM

Child's name__ _____ Age as of 08/1/2026_____
Years / Months

Home address _____City_____ Zip_____

Primary phone_____ Birthdate_____ Sex_____
Month / Day / Year

Father _____ Cell Phone_____

Father's place of employment _____

Mother_____ Cell Phone _____ Business phone_____

Mother's place of employment _____

Primary E-Mail _____

Church affiliation (Parish) _____

Is your child enrolled in another program _____ if yes, where _____

Referred By: _____

My child will attend:

MDO Class (age appropriate 6moths - 3years) _____ Pre-School_____ (3 by 06/30/2026 and fully potty trained) * Pre-K_____ (4 by 06/30/2026) *

*Any child with a date of birth between 7/1/2026 and 8/15/2026 will need to be evaluated to guide and identify the proper classroom placement for the school year

I understand that my child will attend classes on Monday and Wednesday 8:45-2:45. A non-refundable registration fee of $150.00 per child is due when submitting this form

Parent's Signature_____ Date_____

(Complete backside of this form)

Diocese of Memphis Health Form & Release for _____

Health History:
Any Pre-Existing or Present Medical Conditions (including diet) and or learning/behavioral disorders:

_____

_____

Name and dosage of any medication that must be taken:

_____

_____

Any Allergies _____ **Epipen Required**_____ **Allergic to:** _____

_____

Please check all that apply:
___ Hay Fever ___ Asthma ___ Diabetes ___ Insect Stings ___ Epilepsy / Nervous Disorder

___ Frequent Stomach Upsets ___ Heart Condition ___ Physical Handicap ___ Any major illness in the past year?

If any of the above are checked, please give details (i.e. include normal treatment of allergic reactions)

_____

_____

Permission to Treat:
In case of medical or surgical emergency, I hereby give permission to the physician selected by: (school/church/group) **Church of the Holy Spirit MDO** or his/her representative to hospitalize and/or secure proper medical treatment for my above-named child. I understand that I am responsible for the cost of any medical treatments (including surgery) received by my child. I hereby release the directors and staff of this event from all responsibility for sickness and accidents which occur during the event. I understand that I will be contacted immediately in case of an emergency.

_____

Signature Date

Pediatrician _____ Phone Number_____

Insurance Company_____

Policy Number _____Group Number_____

If the situation permits, my first choice of hospital is:

_____

*Please understand that depending upon the seriousness of the situation, your child may be transported to the nearest hospital.

Emergency contacts (other than child's parents) and living in the area that have permission to pick up your child. List at least two if possible.

Name_____Relationship_____Home Phone_____

Home Address_____Cell Phone_____

Name_____Relationship_____Home Phone_____

Home Address_____Cell Phone_____

Name_____Relationship_____Home Phone_____

Home Address_____Cell Phone_____

EMERGENCY RELEASE (to be filled out by office)
Child released to: _____ Destination: _____ Date & Time: _____
Signature of emergency contact: _____Relationship: _____
Staff signature: _____ Position: _____