Quaker Memorial Presbyterian Day School

Enrollment form

Applying for: _____2-Day Class _____3-Day Class _____5-Day Class

Child's FULL NAME _____
Name by which child is called _____ Sex _____
Birthdate _____ Birth Certificate Number _____
Place of Birth _____ Date of Issuance of Birth Certificate _____
Address _____ Phone Number _____
City _____ Zip Code _____
Primary email address _____

Mother's name _____ Home phone _____
Home address _____ Work phone _____
Place of employment/Occupation _____ Cell phone _____

Father's name _____ Home phone _____
Home address _____ Work phone _____
Place of employment/Occupation _____ Cell phone _____

Guardian's name (if different) _____ Home phone _____
Home address _____ Work phone _____
Place of employment/Occupation _____ Cell phone _____

Other children in family (names and ages) _____
_____
Physician _____ Phone _____
How is your child's general health? _____
Does your child have any allergies? _____ If yes, list allergies: _____

EMERGENCY CONTACTS (Other than parents. List two, please)
Name _____ Phone _____
Name _____ Phone _____

Are you a member of Quaker Memorial Presbyterian Church? _____
Tell us about your child's needs (continue on reverse side, if necessary). _____
_____
Previous school attendance? _____ Where? _____
How did you find our about us? _____

I give the staff members of Quaker Memorial Presbyterian Day School permission to obtain emergency medical treatment for my child.
Signed _____ Date _____

RETURN THIS FORM TO:
Quaker Memorial Presbyterian Day School
5810 Fort Avenue
Lynchburg, VA 24502

Quaker Memorial Presbyterian Day School

For Office Use:

Enrollment Received _____
Registration Fee Paid _____
Acceptance Mailed _____
September Tuition Received _____
Medical Form Received _____

Return to:
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5810 Fort Avenue
Lynchburg, VA 24502

Revised 12/03
FWF