GENESIS AFTERNOON ADVENTURE

2024-25 Registration Form

A Ministry of Pendleton Center United Methodist Church
6864 Campbell Blvd. N. Tonawanda, NY 14120
Ph: (716) 625-8306 Fax: (716) 625-8192

Child's Name _____ ❑ M ❑ F **Date of Birth** ____/____/____

Enrollment Choices (✓ One):	**Payment Details:**		
❑ Full-Time: Mon., Wed., & Fri. **11:30AM**-2:00PM (2½ hrs)	Monthly $165/mo, due 1st of each month		
❑ Full-Time: Mon., Wed., & Fri. **12:00PM**-2:00PM (2 hrs)	Monthly $132/mo, due 1st of each month		
❑ Part-Time: **11:30AM**-2:00PM (2½ hrs) ❑ Monday ❑ Wednesday ❑ Friday	**11:30AM**-2:00PM	**1** Day/Week	**2** Days/Week
	Monthly:	$ 75	$ 125
❑ Part-Time: **12:00PM**-2:00PM (2 hrs) ❑ Monday ❑ Wednesday ❑ Friday	**12:00PM**-2:00PM	**1** Day/Week	**2** Days/Week
	Monthly:	$ 60	$ 100

Children 4-5 years of age are eligible for this program. You may bring your child for any portion of the program on the day(s) your child is enrolled. Those registered full-time will be given preference for spaces within the program. You will only receive 9 bills, beginning September 1st. The amount due is the same each month, even though we will be open more days in some months than others.

Child Lives With: ❑ Father ❑ Mother ❑ Both Parents ❑ Other **Family's Church Affiliation:** _____

Father's Name_____

Address_____

_____

Phone_____(H / C / W)

Alternate Ph. _____(H / C / W)

Email: _____

Mother's Name_____

Address_____

_____

Phone_____(H / C / W)

Alternate Ph. _____(H / C / W)

Email: _____

If Other: Name_____ Phone_____

Address_____

Payment Responsibility ❑ Father ❑ Mother ❑ Both Parents ❑ Other

If Other: Name_____ Phone _____

Address_____

Child's Name_____ ***2024-25 Genesis Afternoon Adventure***

Does your child have any allergies? ❑ No ❑ Yes, allergic to: _____

_____

Please provide any family or behavioral information we need to know: _____

_____

Toilet Training Policy: ALL children in 4-yr-old programs must be successfully toilet trained prior to the start of the school year.

Contact Information – Please list in order of preference, the phone numbers where we can reach ***you or someone else*** in case of illness or emergency:

Full Name	**Relationship to child**	**Primary Phone # and Type (Cell, Home, Work)**	**Alternative Phone # and Type (Cell, Home, Work)**
1.			
2.			
3.			
4.			

Child's Source of Medical Care/Primary Care Physician' Name	**Phone Number**
Child's Source of Dental Care/Dentist's Name	**Phone Number**

*****In the event the above persons cannot be reached, I give "Genesis" personnel the authority to sign for emergency medical treatment.**

Signature_____ **Date**_____

Drop Off & Pick Up Authorization List – Please list anyone, ***including those listed above***, you would authorize to drop off or pick up your child from Genesis Preschool. Please let us know if there are any changes to this list during the school year. **Please Note: We will not release your child to ANYONE ELSE unless you have sent in a signed note ahead of time requesting us to do so!**

Full Name	**Relationship to Child**	**Primary Phone**
1.		
2.		
3.		
4.		