



WEIRTON CHRISTIAN CENTER

P. O. Box 2045 117 Ivy Street
Weirton, WV 26062
304-748-2353



PreSchool Program
Afterschool Program
Summer Program

4 YEAR OLD REGISTRATION FORM 2025-2026

Child's Name _____ Birthday _____

Any other Name you use for your child _____ Age _____

Home Address _____ Phone _____

Ethnicity: Hispanic Non-Hispanic **Race:** White Black Multi-Race Asian Other

Child's Clothing Size: _____ Shoe Size: _____

Marital Status: Married _____ Separated _____ Divorced _____ Single _____

PLEASE NOTIFY US IMMEDIATELY WITH ANY CHANGES TO CONTACT INFORMATION.

Father's Name _____ Phone _____

Home Address _____

Employer _____ Position _____

Business Address _____ Bus.Phone _____

Hours of Employment _____

Mother's Name _____ Phone _____

Home Address _____

Employer _____ Position _____

Business Address _____ Bus.Phone _____

Hours of Employment _____

MONTHLY HOUSEHOLD INCOME: (Necessary for WCC FUNDING PURPOSES)

Monthly Wages: _____

Total people in your household. _____

Child Support: _____

Number of children at home _____

Food Stamps _____

Are you interested in other educational programs of the Weirton Christian Center?

Other _____

___ Yes. ___ No

Parent Signature

PARENT E-MAIL _____



WEIRTON CHRISTIAN CENTER

P. O. Box 2045 117 Ivy Street
Weirton, WV 26062
304-748-2353



PreSchool Program
Afterschool Program
Summer Program

HELPFUL HINTS FOR LEARNING

Child's Name _____ Birthday _____

Please list any names and ages of any brothers and sisters your child may have.

Does Your Child Have Any Physical or Mental Health Problems That We Need to Be Aware of In Preschool?

What fears, if any, does child have?

Does child use toilet by himself/herself? Always ___ Usually ___ Sometimes ___ Never ___

Does child have nervous habits? Yes ___ No ___ If so, what?

Does your child have any allergies?

Special Instructions _____

What would you like to see your child learn this year? How would you like to see him/her grow, mature and

develop? _____

What is a Favorite thing of your child's? _____

Please give a brief description: _____



WEIRTON CHRISTIAN CENTER

P. O. Box 2045 117 Ivy Street
Weirton, WV 26062
304-748-2353



PreSchool Program
Afterschool Program
Summer Program

RELEASE STATEMENT

Child's Name _____ may be released to his/her parents

Father _____ or Mother _____

OR THESE INDIVIDUALS:

Name	Address	Phone	Relationship

I understand and agree that my child will not be released to anyone unless they are indicated on this sheet; or a handwritten note signed and dated by parent/guardian is presented to the school upon child's arrival on that day.

Signature _____ Date _____ Password _____

+++++

PHOTO/SOCIAL MEDIA RELEASE

I give my permission to use any photos taken of my child in publicity or promotion for the Center, in newsletters, social media and on our website.

Yes _____ No _____

Parents Signature _____ Date _____

+++++

MEDICAL RELEASE STATEMENT

Child's Physician/pediatrician _____

Address _____ Phone _____

Insurance Company covering Child _____

Policy Number _____ Expiration Date _____

I hereby give my consent to WCC Staff or the nearest hospital to administer necessary treatment to my child, in the event of an emergency at which time I cannot be reached. I give consent to transport by WCC Staff or ambulance if the situation warrants it.

Parents Signature _____ Date _____



WEIRTON CHRISTIAN CENTER

P. O. Box 2045 117 Ivy Street
Weirton, WV 26062
304-748-2353



PreSchool Program
Afterschool Program
Summer Program

EMERGENCY INFORMATION CARD

Please PRINT

Student's Name _____
Last First Middle

Address _____ Home Phone _____

Mother's Address _____ Home Phone _____

Work Phone _____ Cell Phone _____

Father's Address _____ Home Phone _____

Work Phone _____ Cell Phone _____

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached.

Name _____

Address _____ Phone _____

Name _____

Address _____ Phone _____

Date _____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the Physician indicated below and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary.

Signature of Parent or Guardian _____

REMARKS below indicate any chronic condition or defect such as diabetes, rheumatic fever, and ANY ALLERGIES your child has.

Local Physician's Name _____

Address _____ Office Phone _____