



KIDS OF THE KINGDOM REGISTRATION

A Ministry of Floyds Knobs Baptist Church

Child's Full Name _____ Child's Age _____

Child's Preferred Name _____ Child's DOB _____

Child's Address _____ Male/Female _____

Mother _____ Mobile Number _____

Address (if different than child's) _____

Email _____ Employer _____

Church Attending _____ Occupation _____

Father _____ Mobile Number _____

Address (if different than child's) _____

Email _____ Employer _____

Church Attending _____ Occupation _____

Name(s) & Age(s) of Children in Household (other than child above): _____

Emergency Contacts (other than parents):

1. Name _____ Mobile Number _____

Relationship to Child _____

2. Name _____ Mobile Number _____

Relationship to Child _____

Persons Authorized To Pick Up Child (other than listed above): **Must present Photo ID*

1. Name _____ Mobile Number _____

Relationship to Child _____

2. Name _____ Mobile Number _____

Relationship to Child _____

3. Name _____ Mobile Number _____

Relationship to Child _____

Behavior Habits

Known fears _____

Does your child cry easily? _____ Reaction to strangers _____

What are some toys your child likes to play with or favorite things to do at home? _____

Eating Habits

Eating habits and difficulties _____

Food/drink allergies _____

Does your child need help feeding him/herself? _____

Sleeping Habits

Time child wakes (morning) _____ Time child goes to bed _____

Is he/she taking an afternoon nap? Yes No If yes, for how long? _____

Does he/she have a special nap or bedtime routine? _____

Toilet Habits *(Older 3s class and up must be potty trained)*

Is your child potty trained? Yes No Does he/she need assistance? Yes No

Can he/she ask to go? Yes No What word does he/she use? _____

Any additional information you think we should know (i.e. had previous speech, OT, PT, etc)

Which days do you want to register your child for 2024-2025? ****Must choose at least 2 days***

Monday Tuesday Wednesday Thursday

Where will your child attend Kindergarten? _____

Name of Child's Physician _____ Phone Number _____

Hospital Preference _____ Phone Number _____

Allergies _____

Child's Past Serious Illnesses (if any) & Dates _____

Child's Immunizations Up To Date? Yes No ****Please attach immunization record***