



**Hephzibah Baptist**  
**Preschool**  
**Mission Statement**

Our goal at Hephzibah Baptist Church Preschool is to provide a safe, caring, and loving environment where your child can grow in the love of Jesus and develop skills that will give them a Godly foundation for life.

We believe each child has their own learning style. We will provide positive experiences for your child to express themselves in all areas of learning. We will encourage your child to develop spiritual, emotional, social, physical and cognitive skills. We will respect each child as an individual growing at their own level in their own time.

We strive to make a spiritual difference in the life of the individual and the family.

**Days of Operation**

*One Year Olds Mom's Morning Out*  
Mondays, Wednesdays, Fridays

*Two, Three, and Four Year Old Preschool*  
Monday, Wednesday, Fridays

**Time of Operation**

9:00 AM—12:00 PM

**For More Information**

Contact Leanne Lindsay  
HBC Preschool Office  
(919) 366-1212



Hephzibah Baptist Preschool  
1794 Wendell Blvd.  
Wendell NC 27591



**Foundations For Life**

**Proverbs 22:6**

**366-1212**

**Leanne Lindsay**  
**Director**



# **Hephzibah Baptist Church Mom's Morning Out/Preschool Application**

Child's Name: \_\_\_\_\_  
(Last) (First) (Middle) (Preferred Name)

Birth Date: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
(Mailing Address)

Father/Guardian's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Mailing Address)

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Cell Phone/Pager: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Mother/Guardian's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Mailing Address)

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Cell Phone/Pager: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

## **Information About Your Child:**

Allergies: \_\_\_\_\_  
\_\_\_\_\_

Existing Medical Conditions: \_\_\_\_\_  
\_\_\_\_\_

Information concerning your child, which will be helpful (play, eating habits, fears, likes, dislikes): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Doctor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of Dentist: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Cell Phone/Pager: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Cell Phone/Pager: \_\_\_\_\_

Persons your child can be released to with your written permission: \_\_\_\_\_  
\_\_\_\_\_

**Please include a copy of your child's immunization record and your non-refundable registration fee with this application.**

\_\_\_\_\_  
Father/Guardian Signature

\_\_\_\_\_  
Mother/Guardian Signature