

**FIRST BAPTIST CHRISTIAN SCHOOL WEE CARE CENTRE
A MINISTRY OF FIRST BAPTIST CHURCH GRAND CAYMAN
P.O.BOX 10275. KY1-1003 GRAND CAYMAN
920 CREWE ROAD, GRAND CAYMAN CAYMAN ISLANDS
345-949-0691, 345-945-7906, 345-926-3227 FAX# 345-945-5758**

ENROLMENT PROCEDURE

If you are considering enrolling your child at the WEE Care Centre, we encourage you to visit the Centre and meet the Staff. You are welcome to visit Monday - Friday between the hours of 8am -5pm.

Prior to adding your child's name to the list, we would require the following items from you:

- 1. A Completed Application for Admission Form (attached)**
- 2. CI\$150 Deposit (non-refundable)**
- 3. Copy of Immunization Record**
- 4. Copy of Work Permit Listing Child as Dependent (if applicable).**
- 5. Copy of Birth Certificate**
- 6. Photo of child**
- 7. Proof of Insurance covering child**

As soon as the WEE Care office has received the completed Admission Form, your child's name will be placed on the Wait List for his/her age group. You will be notified when space is confirmed. Remaining items must be returned, prior to your child's start date.

Fees are as listed below: Effective September 2010

Full Time	7:30am – 5:30pm	CI \$640.00 per Mo.
Part Time	7:30am – 12:30pm	CI \$520.00 per Mo.
Parent's Day Out 2day (Tues & Thur) 8am – 12:30pm		CI \$295.00 per Mo.
Parent's Day Out 3day (Mon.Wed. & Fri.) 8am-12:30pm		CI \$415.00 per Mo.

****FOR ALL CHILDREN less than 2 years PLEASE ADD CIS 30 PER Mo. ****

Should you have any questions relating to the programmes, please do not hesitate to contact the WEE Care office 345-949-0691 or email weecare@fbcs.edu.ky

FIRST BAPTIST CHRISTIAN SCHOOL WEE CARE CENTRE
A Ministry of First Baptist Church of Grand Cayman

APPLICATION FOR ADMISSION (one form per child)

Surname: _____ **Male / Female**

Christian name of Child: _____

Date of Birth: Day _____ Month _____ Year _____

Place of Birth: _____

Street Address: _____

P.O.Box: _____ **Postal Code** _____ **District** _____

Telephone # Home: _____ **Cell:** _____ **Work** _____

E-mail: Mom _____ Dad _____

Nationality: Caymanian: _____ **Status:** _____ **Other (Specify)** _____

Does your child have an ALLERGY? Yes / No

Specify: _____

Any Medical Condition requiring special Specify: _____

Any other Special Requirements: _____

Name of Siblings who attend FBCS / WEE Care _____

Name of Previous Day Care (if any) _____

Please CIRCLE the Programme you will need:

Infant 3-12 months Toddler 12-18months 2 year 3 year Pre-K 4yr.

Please CIRCLE the appropriate programme: Full time (Mon.-Fri.) 7:30am-5:30pm

Part time (Mon.-Fri.) 7:30am-12:30pm

3 Day (Mon. Wed. & Fri.) 8am -12:30pm 2Day (Tues. & Thurs.) 8am -12:30pm

Preferred Start Date: _____

Name of Mother: _____

Name of Father: _____

Occupation of Mother: _____

Employer: _____

Phone H# _____ **(w#)** _____ **(c#)** _____

Occupation of Father: _____

Employer: _____

Phone # H _____ **(w #)** _____ **(c #)** _____

Guardian's name: _____ **Ph. #** _____

Ins. Company: _____ **Policy #** _____

Group # _____

For Office use only.

Date Registration Fee of CIS150 paid: _____ **Rec. #** _____

Birth Certificate Received: _____

Immunization Record Received: _____

Proof of Insurance Received: _____

Confirmed Start Date: _____