

PLACEMENT CONTINGENT UPON AVAILABLE OPENINGS.

**PLEASE CHECK ONE:**

\_\_\_ Pre-K Class M/W/Th -Age 4 by Sept. 1

\_\_\_ Pre-K Class M/W/Th/F -Age 4 by Sept. 1

\_\_\_ Preschool Class T/F -Age 3 by Sept. 1

\_\_\_ Preschool Class T/W/F -Age 3.5 by Sept 1

All classes are 9:30 a.m. to noon.

\_\_\_ we are interested in a full day 9:00 - 3:00 p.m. option Wed.

Date _____	
Registration Paid	Amount
Check# _____	_____
Cash	_____
Tuition Paid	
Check# _____	_____
Cash	_____

**Preschool Registration and Agreement for Care — Trinity Lutheran Preschool**

Name of Child \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex (M)\_\_\_ (F)\_\_\_

Does Child prefer nickname? \_\_\_\_\_ Email address \_\_\_\_\_

Child's Home Address \_\_\_\_\_

Father's Name \_\_\_\_\_ -Address (if different) \_\_\_\_\_

Cell# \_\_\_\_\_ Home# \_\_\_\_\_

Mother's Name \_\_\_\_\_ -Address (if different) \_\_\_\_\_

Cell# \_\_\_\_\_ Home# \_\_\_\_\_

Church Membership \_\_\_\_\_ Church Location \_\_\_\_\_

Siblings (name and age) 1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

Other than parents, the following people are authorized to drop off and pick-up from preschool:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

Please list all allergies (food, medicine, etc.): \_\_\_\_\_

Persons to notify in emergency if parents are not available:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone 1 \_\_\_\_\_ Phone 2 \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone 1 \_\_\_\_\_ Phone 2 \_\_\_\_\_

**How did you learn about Trinity Lutheran Preschool?** \_\_\_\_\_

Health Insurance Company \_\_\_\_\_

Child's Physician or Medical Service to be used \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Address \_\_\_\_\_

In case of emergency, Trinity Lutheran Preschool is directed to take care of the following steps:

- (1) Contact the parents if at all possible. If not,
- (2) Contact the physician listed above. If not available,

You are directed to do one of the following checked items:

- \_\_\_\_(a) Contact any available local physician, or
- \_\_\_\_(b) Use the Emergency Room facilities at the Reading Hospital.

I/We also acknowledge the fact that Trinity Lutheran Preschool is not liable for any accidents or injuries sustained during the operation of the school. Any and all medical expense incurred due to an accident or injury at the school will be the full responsibility of the parents.

By signing this form, we the parent(s) give our full consent for our child to attend Trinity Lutheran Preschool if admission is still available.

Date \_\_\_\_\_ (Signed) \_\_\_\_\_

Date \_\_\_\_\_ (Signed) \_\_\_\_\_

Please denote immunization dates on the chart below or attach a copy of the child's immunization record.

	Dose 1	Dose 2	Dose 3	Dose 4
DTaP				
Hepatitis A			—	---
Hepatitis B				---
HiB (PRP-OMP)				---
MMR (Measles, Mumps, Rubella)		—	---	---
Pneumonia				

Does the child have any speech, hearing, eyesight, or any other special health problems? (circle) Yes No

Explain: \_\_\_\_\_

Does your child have any special emotional/spiritual problems of which the school's staff should be aware? If so, please describe briefly. \_\_\_\_\_

Does your child have any special social problems of which the school's staff should be aware? If so, please describe briefly. \_\_\_\_\_