## 2020-2021 GVBC PRESCHOOL REGISTRATION

For Administrative Use Only				
Reg Fee	Ck #/Cash			
Rec'd by	Date			

Enrolling for (circle of	one): Toddlers	(MWF) 2's (MW	F) 3's (MWF) or (M-F)	4's (MWF) 4's (M-F)
Monthly Tuition: 1 Day = \$60 2 Days = \$95 3 Days = \$145 5 Days = \$185	Days = \$95 $Days = $145$	Registration Fee:	\$35 if paid by May 15, 2020 (non-refundable) \$40 if paid after May 15, 2020 (non-refundable) \$20 for any additional children in same family	
	Days — \$163	Activity Fee:	\$5.00 for the 2 year old class \$30.00 for 3 & 4 year old classes (Does not have to be paid with registration.)	
Child's Full Name:_			Name Used:	
Birth Date:		Sex:		
Mother's Name:			_ Father's Name:	
Street Address:				
			Zip Code:	
Home Phone:		En	nail:	
			owed Separated _	
Please list any custod	ly/visitation arra	angements:		
Parent's Occupation:	Father:		Work Phone:	
1	arent's Occupation: Father: Work Phone: Cell Phone:			
	Mother: Work Phone:			
			Cell Phone:	
Person(s) to be notifi Name	ed in case of an	emergency: <i>Relati</i> Relation		e No.
1)				
Sisters (name and age	0 1)			

Adults in Home Besides Parents: \_\_\_\_\_ Relation: \_\_\_\_\_

Has your child been enrolled in a presc	hool/daycare before? If so,	when and where?
Is your child toilet trained?		
Does your child have any special fears/	anxieties that we should be	aware of? If so, please describe.
Please list any special interests/play act	civities of your child.	
Is any language other than English used	d in the home? If so, please	describe.
Persons authorized to pick up your chil	d:	
Name	Relationship	Phone No.
1)		
2)		
3)		
Child's Doctor:		
Office Address:		
Child's Dentist:		
		Phone No:
Hospital Preference:		
List Any Allergies:		
event of an illness or accident, which rebe located, I give permission for Glerauthorize treatment. I will not hold the	equires immediate medical t an View Baptist Preschool la e center nor medical person	. Antiseptic cream and band-aids. In the reatment, at a time when a parent canno Personnel designated by the Director to nnel responsible. This is done with the ats, the child's physician, and other per
Signed:		Date:

## **Immunization Requirements**

A medical record of your child's immunization must be on file in the Preschool Director's office prior to the first day of school. For the children's safety, there will be no exceptions to this rule.

## **Medical Form to be Completed by Health Care Provider**

Child's Name:		
Last	First	Middle
List any allergies (food, insect stings, medicin	ne, etc.)	
Is this child in good health and physical condi	ition?Yes	_ No (please explain)
Does this child have any health problems or o in preschool? If yes, please exp	olain:	
Special attention or care needed:		
Does this child have any communicable disea	uses? If yes, plea	se explain:
Is this child current on all immunizations for	his/her age? Yes	No
Please attach a copy of immunizations and	dates given.	
Signature of Health Care Provider	Date	
Address:		
Phone Number:		