2018-2019 GVBC
PRESCHOOL REGISTRATION

For Administrative Use Only

Reg Fee _____ Ck #/Cash _____
Rec'd by _____ Date _____

Enrolling for (please circle one): Toddlers (MF) 2's (MWF) 3's (MWF) 4's (MWF) 4's (M-F)

Monthly Tuition: 1 Day = $60
2 Days = $95
3 Days = $140
5 Days = $185

Registration Fee: $35 if paid by May 15, 2017 (non-refundable)
$40 if paid after May 15, 2017 (non-refundable)
$20 for any additional children in same family

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: _____

City/State: _____ Zip Code: _____

Home Phone: _____ Email: _____

Marital Status of Parents: _____ Married _____ Widowed _____ Separated _____ Divorced

Please list any custody/visitation arrangements: _____
_____

Parent's Occupation: Father:_____ Work Phone: _____
Cell Phone: _____
Mother:_____ Work Phone: _____
Cell Phone: _____

Person(s) to be notified in case of an emergency: *Relative or friends (local)*

Name	Relationship	Phone No.

1) _____

2) _____

Church Affiliation or Preference: _____

Brothers (name and age of each): _____

Sisters (name and age of each) :_____

Adults in Home Besides Parents: _____ Relation: _____

Has your child been enrolled in a preschool/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 activities of your child.

Is any language other than English used in the home? If so, please describe.

Persons authorized to pick up your child:

	Name	Relationship	Phone No.
1)			
2)			
3)			

Child's Doctor: _____

Office Address: _____ Phone No: _____

Child's Dentist: _____

Office Address: _____ Phone No: _____

Hospital Preference: _____

List Any Allergies: _____

_____

_____

I hereby give permission for you to administer general first aid, i.e.. Antiseptic cream and band-aids. In the event of an illness or accident, which requires immediate medical treatment, at a time when a parent cannot be located, I give permission for Glenn View Baptist Preschool Personnel designated by the Director to authorize treatment. I will not hold the center nor medical personnel responsible. This is done with the understanding that every attempt will be made to contact the parents, the child's physician, and other persons listed for emergency contact.

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, medicine, etc.)

_____

Is this child in good health and physical condition? _____ Yes _____ No (please explain)

_____

Does this child have any health problems or other conditions that would affect his/her participation in preschool? _____ If yes, please explain: _____

_____

Special attention or care needed: _____

Does this child have any communicable diseases? _____ If yes, please 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: _____