REGISTRATION FORM

Please return with nonrefundable $150.00 and first month's tuition fee to:
Church of the Covenant
267 East Beau Street
Washington, PA 15301-4755
Telephone: 724-222-0190 ext 121
Fax: 724-222-0196

office use only:
Date Rec._____ Time_____
Registration fee paid_____
Class Assignment_____
Acceptance Mailed_____

FULL NAME OF CHILD_____

(Circle the name by which the child is called)

AGE: ____M ____F DATE OF BIRTH_____

CLASS FOR WHICH CHILD IS ENROLLING: School District_____

TWO DAY Three year old or very young Four (9:30am-12:00 pm) Tuesday/Thursday____
$130.00/month (12:30-3:00 pm) Tuesday/Thursday____

THREE DAY Four year old (9:00 am-12:00 pm) Monday/Wednesday/Friday____

$155.00/month (12:30 pm-3:30pm) Monday/Wednesday/Friday____

FOUR DAY…Transition Class 5's (9:00 am-12:00 pm) Monday/ Tuesday/Wednesday/Thursday____
$185.00/month (Fives who have already attended 1 yr. of Preschool)

(12:30-3:30)An Afternoon session is enrollment dependent _____

If class time, which I have selected, is full, I will accept the other class (circle one)Yes No

Home Address: _____ Phone #: _____
City_____ Zip Code _____ Cell Phone: _____

Mailing Address (if different from above):_____

Mother's Name: _____ Occupation: _____

Business Address: _____ Office Phone: _____

Father's Name: _____ Occupation: _____

Business Address: _____ Office Phone: _____

Other children in family (names and ages): _____

_____

Other adults living with your family (names only): _____

_____

Special people in your child's life (babysitters, etc):_____

_____

General Health of Mother: _____ Father: _____ Other children: _____

Religious affiliation (church): Father: _____ Mother: _____

Child's previous school attendance: Where?: _____ When?: _____

What contact does child have with other children?: _____

_____

Does he/she have imaginary playmates?: _____

What are his/her dominant play interests?: _____

Indoors?:_____ Outdoors?:_____

GENERAL HEALTH HABITS CONNECTED WITH:

1. Food allergies?: _____
2. Rest: Bedtime (pm)_____ Time of waking (am):_____
   Afternoon nap?: _____ Time? _____
3. Elimination Any problems with toilet habits?: _____
4. Emotional Development: Fears:_____ Jealousy:_____
   Physical Development: _____ Delays:_____ Concerns:_____
   Dependence on others?: _____ Nail biting/Thumb sucking/Other habits? _____
5. Child tends to be (right): _____ (left): _____ handed.
6. Any previous developmental testing/concerns yes ___ no ___ if yes explain:
7. Does your child have an IEP? Yes _____No _____

Please add any other information you might wish which will contribute to a better understanding of your child and his/her needs.

_____

In case of MEDICAL EMERGENCY (when neither parent can be located by phone), call:

Name: _____ Phone number: _____

Address: _____

Name: _____ Phone Number: _____

Address: _____

In case of medical emergency, when no authorized person can be located by phone, consult:

Doctor: (1st choice): _____ Phone Number: _____

Doctor (2nd choice): _____ Phone Number: _____

Hospital: _____ Phone Number: _____

The staff will be in contact with a child's parents in ANY emergency. In the event such contact is impossible, I acknowledge that the staff is in loco parentis and I consent to the staff providing and procuring any emergency medical treatment, which may be necessary.

……

List the names and relationships of those persons whom you authorize to pick up your child/children at the end of school session:

Name	Relationship	Contact #
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you are willing to serve as a volunteer in your child's classroom, (on occasion) to share your talents, a special hobby or interest, etc.,

please sign: _____

THE ATTACHED MEDICAL FORM MUST BE FILLED OUT BY YOUR PHYSICIAN WITHIN SIX MONTHS OF THE OPENING OF SCHOOL AND RETURNED TO THE SCHOOL ON OR BEFORE THE FIRST DAY OF SCHOOL.

Refund Policy: A registration fee of $150.00 and first month's tuition is to be paid at time the parent turns in the registration form for the child's admission to school. The fee *and* first month's tuition is **NON- REFUNDABLE** for any reason including potty training issues. The only exception made is in the event the family relocates outside of the country. Please keep this in mind before registering your child for the preschool. If your child is not potty trained by start of school year you can hold you spot in the class by paying monthly tuition until child is potty trained; OR you can pull the child from the school and lose your registration fee and first month's tuition. If you pull your child and they are later potty trained and there is a space available the preschool you can take that space; The preschool will apply your registration fee and first month's tuition to the remainder of the school year. Please contact the preschool director if you have any questions regarding this policy.

MEDICAL FORM

CHURCH OF THE COVENANT PRESCHOOL

Child's Name_____ Birth date_____

Is child under regular care of a doctor for an unusual condition? _____Yes _____No

If yes, describe the condition_____

Is child on regular medication? _____Yes _____No If yes, name_____

Has child had any communicable diseases? _____Yes _____No If yes, name_____

If yes, when_____

General Health: Eyes_____ Ears_____

Has child any history of convulsions? _____Yes _____No

Is child subject to any dietary regulations?_____Yes _____No

If yes, what are they?_____

Has child had any major surgery? _____Yes (name)_____ No_____

Has child had any serious accidents? _____Yes _____No Describe_____

Does child have any physical reason for not participating in normal school activities such as outdoor play? _____Yes _____No

If yes, describe_____

Does child have allergies? _____Yes _____No If yes, list those which need to be considered by the school:

_____

IMMUNIZATION RECORD

	Date 1st Dose	Date 2nd Dose	Date 3rd Dose	Date 1st Booster	Date 2nd Booster
DPT	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____
Measles (Rubeola)	_____	_____	_____	_____	_____
Mumps	_____	_____	_____	_____	_____
Rubella	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____
HIB	_____	_____	_____	_____	_____
Other					

PHYSICIAN'S SIGNATURE_____