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__________________ EMAIL: __________________

CLASS FOR WHICH CHILD IS ENROLLING: School District__________________

TWO DAY Three year old or very young Four (9:30am-12:00 pm) Tuesday/Thursday____
$150.00/month (12:30-3:00 pm) Tuesday/Thursday____

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

$175.00/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____
$200.00/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 <u>MEDICAL EMERGENCY</u> (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 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____