

# REGISTRATION FORM

Please return with nonrefundable \$175.00 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\_\_\_\_  
\$165.00/month      (12:30-3:00 pm)      Tuesday/Thursday\_\_\_\_

THREE DAY      Four year old      (9:00 am-12:00 pm)      Monday/Wednesday/Friday\_\_\_\_  
\$200.00/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\_\_\_\_  
\$215.00/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: (1<sup>st</sup> choice): \_\_\_\_\_ Phone Number: \_\_\_\_\_

Doctor (2<sup>nd</sup> 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.

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

<u>Name</u>	<u>Relationship</u>	<u>Contact #</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 \$175.00 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	Date	Date	Date 1 <sup>st</sup>	Date 2 <sup>nd</sup>
	<u>1<sup>st</sup> Dose</u>	<u>2<sup>nd</sup> Dose</u>	<u>3<sup>rd</sup> Dose</u>	<u>Booster</u>	<u>Booster</u>
DPT	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____
Measles (Rubeola)	_____	_____	_____	_____	_____
Mumps	_____	_____	_____	_____	_____
Rubella	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____
HIB	_____	_____	_____	_____	_____
Other					

PHYSICIAN'S SIGNATURE \_\_\_\_\_