

Macland Presbyterian Preschool Registration Application 2007-2008 School Year

Child's Name: _____ Name called _____

Sex: _____ Birthdate: _____ Age as of September 1st _____

Address _____ City _____ State _____ Zip _____

Home Phone: _____ Mom's cell phone _____ Dad's cell phone _____

Father's Name: _____ Employer _____ Work Phone: _____

Mother's Name: _____ Employer _____ Work Phone: _____

Current Marital Status: Married ___ Separated ___ Divorced ___ ___ You may include our address,
Child lives with: Both Parents ___ Mother ___ Father ___ Other ___ home phone, and family email
in the school directory.

Class registering for: ___ 4 year ___ 3 year (___ 2days ___ 3days) ___ 2 year (___ 2days ___ 3days)

Family Email _____ Church affiliation: _____

Please list any allergies or medical problems _____

Child's Doctor _____ Doctor's Phone Number _____

Please list any dietary restrictions your child has: _____

I agree to pay my child's tuition monthly, September through May. If tuition is not paid by the 10th of the month, a \$20.00 late fee will be assessed. If tuition and late fee are not received by the 30th of the month, your child will be withdrawn from school. There are no credits for absences. I have read and agree to the above. Attached is my registration fee to reserve my child's space. I understand that this fee is non-refundable if I decide not to enroll my child or withdraw during the year.

Parent's signature _____ Date _____

Two Names and phone # (other than Parents) to call in case of an emergency

1. _____ 2. _____

My child has permission to be picked up by the following people other than myself:

1. _____ Relationship to child _____ Phone# _____

2. _____ Relationship to child _____ Phone # _____

To Whom It May Concern:

I, _____, hereby authorize Macland Presbyterian Preschool to sign on my behalf any and all forms required in order to obtain emergency medical or hospital care for my child, _____, and specifically authorize and request that necessary treatment be provided by you to my child. A photocopy of this authorization and consent for medical treatment shall have the same force and effect as the original.

Parent's Signature _____ Date _____

Insurance Carrier _____ Policy # _____

Office Use: Date _____ Registration Fee _____ Emergency Info _____ Immunization _____

LAST NAME

FIRST NAME

TEACHER

DAYS