

Greenwood United Methodist Preschool Registration Form for 2010-2011 School Year
Fill out one form for each child.

Mail completed form and \$70 nonrefundable deposit to: 525 N. Madison Avenue, Greenwood, IN 46142

Child's Name: _____

Birthdate: _____

Preschool class to be enrolled in: (circle one): 3s / 4s / Pre-K A.M. / Pre-K P.M.

Nonrefundable Fee=\$70 Circle Monthly Fee: 3s & 4s=\$75/mo.; Pre-K=\$100/mo.

Child's address: _____
City State Zip

Home Phone: _____ Home E-mail: _____

Mother's Name: _____ Cell Phone: _____

Father's Name: _____ Cell Phone: _____

Emergency 1st Contact Name: _____ Phone: _____

Babysitter's Name: _____ Phone: _____

Authorized Escorts for my child:

Name: _____ Phone: _____ Relationship to child: _____

Name: _____ Phone: _____ Relationship to child: _____

Name: _____ Phone: _____ Relationship to child: _____

Parent/Guardian Agreement:

I consent to the enrollment of my child _____ with the Greenwood United Methodist Preschool and agree that the Greenwood United Methodist Preschool shall not be responsible in case of sickness or injury of this child while in the attendance of the Preschool facility or to and from the facility.

I give my consent for my child to take part in field trips or excursions under proper supervision. I will furnish a car seat if I cannot attend.

I agree to pay the monthly fee of \$_____ and I will carry out the rules and regulations of the Preschool.

I further agree that in case of accident or injury, emergency medical care may be given in the event that I cannot be contacted immediately.

Parent and/or Guardian Signatures:

_____ Date: _____

You will be contacted by mail mid-August with Preschool orientation & class information.
The first day of school for 2010-2011: Pre-K-Tues. Sept. 7; 3s/4s-Weds. Sept. 8.

Family History:

Child's Name: _____ Nickname: _____

Mother's present occupation: _____ Former occupation: _____

Mother's work address: _____ Phone: _____

Father's present occupation: _____ Former occupation: _____

Father's work address: _____ Phone: _____

Are parents divorced? _____

Other children in family:

Name: _____ Age: _____ Sex: (circle one) Male Female

Name: _____ Age: _____ Sex: (circle one) Male Female

Name: _____ Age: _____ Sex: (circle one) Male Female

Religious Affiliation: Mother _____ Father _____

Would you like more information about our church? (circle one) Yes No

Would you like to be contacted by Pastor Bill Hoopes or a church staff member? Yes No

Speech:

Does he/she speak plainly so others (besides those at home) can understand? Yes No

Are any foreign languages spoken in the home? Yes No What language(s): _____

Is he/she enrolled in a speech program? Yes No If so, where? _____

Personality:

Does he/she have any special fears? Yes No

If so, please explain: _____

Are you aware of any special problems such as aggression, anger, anxiety, etc? Yes No

If so, please explain: _____

Is there any information which we should have concerning your child which would help us to better understand him/her? Yes No

If so, please explain: _____

What previous group experiences has your child had? _____

Emergency Health Record (to be filled out by parent)

Child's Name: _____ Age: _____ Sex: (circle) Male Female

Address: _____
City State Zip

Birthdate: _____ Birthplace: _____
City State Country

Parent/Guardian: _____ Home Phone: _____

Mother's work phone: _____ Cell phone: _____

Father's work phone: _____ Cell phone: _____

If parents are not immediately available in an emergency contact:

Name	Relationship	Phone
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Physician Name: _____ Phone: _____

Hospital: _____ Phone: _____

In case of emergency, the school may call the family physician to examine my child.

(Without such permission, the school assumes no responsibility for emergency medical attention.)

Circle one: Yes No

Signature of Parent/Guardian: _____ Date: _____

Medical Record (to be filled out by parent)

Name of child's doctor: _____ Phone: _____

Office Address: _____
City State Zip

Serious Accidents: _____

Serious Illnesses: _____

Operations: _____

Hospitalization: _____

Handicaps (eyes, ears, feet, etc.) _____

Allergies: _____

Please attach a record of your child's immunizations. (required)