2017-2018 School Year

Cold Springs Preschool

2550 Cold Springs Road, East,

Concord, NC 28025

Date:_____

Class: _____

Registration Fee paid ____

Phone: 704-782-1875; Fax: 704-793-4629; Email: preschool@coldspringsumc.org

Child's Full Name:_____

Name called:_____ Boy_____ Girl_____

Date of Birth:_____ Current Age_____

Address:_____

Child lives with: Both parents Mother Father Other:_____

Select:	Class	Days	Cost
	1's	T/TH	$120
	1's	T/W/TH*	$165
	2's	T/TH	$120
	2's	M/W/F	$165
	2's	T/W/TH	$165
	2's	M-F	$199
	3's	T/TH	$120
	3's	M/W/F	$165
	3's	T/W/TH	$165
	3's	M-F	$199
	4's	M-F	$199

- Select which class you are registering for and return this form with the registration payment to secure enrollment.
- **Registration Fee $60** ($10 off registration fee if registered by April 1, 2017) (Non-refundable).
- **Preschool hours: 8:45am—12:30pm.**
- You provide a peanut-free lunch for your child.
- All children must be the classroom age by August 31 and be current on immunizations.
- When registering my child for preschool, I understand it is a 9-month commitment. The annual tuition is broken down into 9 equal monthly payments. The first month's tuition is due by August 1 and then on the 1st-5th of each month, September—April.
- *We must have at least 3 children enrolled in the 1-year old class by August 1, 2017 to offer this new 3-day class option.

Mother's/Guardian's Name:_____

Address (if different from above):_____

Cell #:_____ Email: _____

Home #:_____ Preferred method of contact: (please circle)

Work #:_____ Cell # Home # Work # Email

Father's/Guardian's Name:_____

Address (if different from above):_____

Cell #:_____ Email: _____

Home #:_____ Preferred method of contact: (please circle)

Work #:_____ Cell # Home # Work # Email

Child's Name:_____

In case of emergency (if mom/dad are not available):

Name:_____ Relationship:_____

Cell #:_____ Other #:_____

Name:_____ Relationship:_____

Cell #:_____ Other #:_____

Name:_____ Relationship:_____

Cell #:_____ Other #:_____

Physician Information:

Name of Child's Doctor:_____

Physician's Phone #:_____

Name of Child's Dentist:_____

Dentist's Phone #:_____

I give my permission to my child's teacher or Preschool Director to authorize Emergency care for my child in the event: No family emergency contacts can be reached, the child's family physician can't be reached, or the Preschool staff deems the situation to be an emergency.

Parent/Guardian signature:_____

Date:_____

Child's Name:_____

Medical History

My child has allergies: ☐ Yes ☐ No If yes, please indicate allergies below:

Peanuts		Latex	
Tree Nuts		Bee/Wasp/Insect stings	
Shellfish		Animal Dander (specify)	
Eggs/Dairy		Other (specify)	

Will medical devices be provided to preschool? ☐ Yes ☐ No

If yes, in case of emergency, my child will have the following medical devices at school provided by the parent/guardian:

(Please circle) Epi-pen Asthma Inhaler Other:_____

Please list any illnesses that your child has had:

Chicken Pox		Ear Infections	
Influenza		Emotional Disorders	
Pneumonia		Other	
Scarlet Fever		Other	

Immunizations and Tests:

(We must have a copy from your child's physician)

DPT Series		
Measles Vaccination		
Polio Vaccination		
Tuberculin Test		
Booster		
MMR Vaccination		
Other:		

Date of last physical exam:_____

Has your child had an eye exam? ☐ Yes ☐ No Hearing test? ☐ Yes ☐ No

Has your child been diagnosed with any medical conditions the preschool should be aware of?

☐ Yes ☐ No If yes, please indicate:_____

_____

Parent/Guardian signature:_____

Date:_____