



2018-2019 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 9, 2018) (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, 2018 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: _____