

Application for Enrollment 2018/2019

St. Michael Lutheran Preschool
 2131 Getz Road
 Fort Wayne, Indiana 46804
 (260) 432-2033

_____	Fee
_____	Application
_____	Emerg Contact
_____	Medical Forms

Please complete this form and return it to the church office. Registration fee of \$85 must accompany your application and is non-refundable.

Check your choice for the 2018/2019 school year:		
<input type="checkbox"/>	3 year old class (T/TH 8:30a-11:00a)	\$100 mo. 3 by August 31, 2018
<input type="checkbox"/>	4 year old class (M/W/F 8:30a-11:00a)	\$130 mo. 4 by August 31, 2018
<input type="checkbox"/>	4/5 year old class (M-F 12:30p-3:00 p)	\$175 mo. 4 by August 31, 2018

How did you hear about our preschool? _____

CHILD INFORMATION (Also include a copy of your child's immunization records.)

Child's full name: _____
 Name child goes by: _____
 Date of birth: _____ Sex: M F
 Date of Baptism (month and year): _____
 Child's home address: _____
 Phone number for child to learn: _____ Home Zip Code: _____
 Ethnic Origin (used for reporting purposes only): _____

PARENT INFORMATION

	Mother	Father
Name		
Occupation		
Employer		
Home Phone		
Work Phone		
Cell Phone		
Address (if different)		
Email Address		
Marital Status	Mar / Sep / Div / Wid / Single	Mar / Sep / Div / Wid / Single
Church Name		
Member	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY INFORMATION

Brothers and/or sisters (please indicate ages and whether they live with the child):

Name	Age	In Home With Child?	
		<input type="checkbox"/> Y	<input type="checkbox"/> N
		<input type="checkbox"/> Y	<input type="checkbox"/> N
		<input type="checkbox"/> Y	<input type="checkbox"/> N
		<input type="checkbox"/> Y	<input type="checkbox"/> N

Please list any other persons living with the child and their relationship (if any) to the child:

If there has been a separation or divorce, with whom is the child living? _____

If child is living with someone other than parents, please complete:

Name: _____

Address: _____

Phone: _____

Relationship: _____

Church membership: _____

PICK-UP OF CHILD

Persons authorized to pick up child: _____

Persons who may NOT pick up child: _____

If there is a cancellation or school emergency, who should be contacted during school hours: _____

Relationship and phone #: _____

PERSONAL HISTORY

Is your child right-handed or left-handed? _____

Has your child had a previous group interaction or pre-school experience? _____

If so, where and when? _____

Does your child have any allergies? _____

Are there any medical problems of which we should be aware? _____

Does your child have any problems with his speech and/or hearing? _____

What age was your child toilet trained? _____

What words does your child use for toileting? _____

Does your child have any fears? _____

What methods of discipline are most effective with your child? _____

What reaction does your child have to your discipline? _____

Does your child follow directions? _____

When your child hears a story, does he/she sit still and listen? Yes No

Favorite activities with:

Mother: _____

Father: _____

Siblings: _____

Does your child play with other children? Yes No

How old is the child's most frequent friend? _____

Is your child more often around adults or children? Adults Children

Does your child have any imaginary friends? Yes No

Does your child have a "security blanket"? Yes No

How often and when is it needed/used? _____

What is your child's favorite kind of outdoor game? _____

What is your child's attitude about sharing? _____

What is your child's concept of God? _____

What would you like your child to get out of his pre school experience? _____

I/we agree to pay St. Michael Lutheran Church the tuition costs for my/our child attending St. Michael Lutheran Pre-School. I/we further agree that should I/we become delinquent in paying those tuition costs that I/we will agree to reimburse St. Michael Lutheran Church any and all costs that may be incurred, including attorney fees and court costs, in collecting that delinquent amount from me/us.

Signature of Parent/Guardian

Date

Signature of Parent/Guardian

Date

MEDICAL EMERGENCY AUTHORIZATION FORM

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Child's Name: _____ Birth date: _____
Address: _____ City/State/ZIP: _____
Home phone: _____
Mother's Name: _____ Father's Name: _____
Employer: _____ Employer: _____
Work phone: _____ Work phone: _____
Cellular phone: _____ Cellular phone: _____
Name of relative/friend: _____
Home phone: _____ Work and/or Cellular phone: _____
Child's physician: _____
Address: _____
Phone: _____ Hospital preference: _____
Child's dentist: _____
Address: _____
Phone: _____
Special instructions if child is injured or ill: _____

MEDICAL RELEASE: I authorize St. Michael Lutheran Preschool to seek emergency medical treatment for my child. I give permission to the emergency physician to secure proper emergency treatment and to order injection, anesthesia, or other emergency treatment if I (we) cannot be contacted. It is understood that a conscientious effort will be made to locate me or my spouse before action is taken. But if it is not possible to locate us, I accept the expense. In the event of life-threatening emergency, I understand that "911" will be called to take my child to my preferred hospital if possible or to the closest available facility.

Signature of Parent/Guardian

Date

Signature of Parent/Guardian

Date

CHILD'S HEALTH RECORD

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This report is to be filled out by a licensed physician, physician's assistant or nurse practitioner who has seen the child within the last 12 months.

Child's Name: _____ Birth date: _____
Address: _____ Sex: M F

Past illnesses (Check those the child has had and give approximate dates.)

<input type="checkbox"/> Chicken pox _____	<input type="checkbox"/> Rubeola _____	<input type="checkbox"/> Rubella _____
<input type="checkbox"/> Rheumatic fever _____	<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Hay fever _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Whooping cough _____	<input type="checkbox"/> Poliomyelitis _____
<input type="checkbox"/> Epilepsy _____	<input type="checkbox"/> Mumps _____	<input type="checkbox"/> Other (explain): _____

This child is / is not physically or emotionally able to participate in the early childhood program named above. Comments: _____

Surgery/accidents/illness/chronic or handicapping problems: _____

Describe any physical condition requiring special attention by Pre-School staff: _____

Medication(s) prescribed: _____

Allergies that staff should be aware of: _____

Prescribed routine: _____

Dental: _____

Please check: No visible decay Decay present Exam recommended

Tuberculin test given: Yes No Date: _____ Result: _____

Vision screening: _____ Hearing screening: _____

Date of my most recent examination of child: _____

Signature of licensed physician,
physician's assistant or nurse practitioner

Date

Please print physician's name and address

PLEASE INCLUDE COPY OF CHILD'S CURRENT IMMUNIZATION RECORD