First Presbyterian Preschool

400 Bayshore Boulevard, Jacksonville, NC 28540
(910) 455-2434 • www.jacksonvillepresbyterian.com

Child's Name: _____ Age: _____

Please indicate your first and second program choice:

__ 5-day program – Tuition is $240 per month

__ 3-day program – Tuition is $220 per month

__ 2-day program – Tuition is $220 per month

Daily Schedule

- The preschool day begins at 9:00 A.M. (drop-off at 8:55 A.M.) and ends at 1:00 P.M.
- Children are provided with a snack and lunch each day.
- Late fees will be applied for late pick up in the afternoons.
- Please consult handbook for details.

Tuition

Tuition is due by the 10th of each month. The tuition is a flat rate and does not change because of illness, absences from school or holidays. The first and last months' tuition are due upon enrollment.

Registration

A non-refundable registration fee of $80 is required at the time of application in order to reserve you child's enrollment.

Payment

All checks should be made payable to **First Presbyterian Preschool**.

For Office Use Only

Date Received _____ Received by _____

First Presbyterian Preschool
REGISTRATION

Child's full name: _____

Child's preferred name: _____

Date of Birth: _____ Age: _____ Gender:_____

Child's home address: _____

Child's home phone: (_____) _____-_____

PARENT/GUARDIAN INFORMATION

Mother's Information

Name: _____

Home address: _____

Home phone: (_____) _____-_____ Cell phone (opt.): (_____) _____-_____

Work phone: (_____) _____-_____

Occupation: _____ Place of employment: _____

Father's Information

Name: _____

Home address: _____

Home phone: (_____) _____-_____ Cell phone (opt.): (_____) _____-_____

Work phone: (_____) _____-_____

Occupation: _____ Place of employment: _____

Siblings

Name: _____ Gender _____ Age _____ Same home: YES or NO

Name: _____ Gender _____ Age _____ Same home: YES or NO

Name: _____ Gender _____ Age _____ Same home: YES or NO

Please list anyone else living with the child and their relationship to the child:

_____

PICK-UP

Persons AUTHORIZED to pick up child: _____

Persons who may **NOT** pick up child: _____

First Presbyterian Preschool
PERMISSION FOR HEALTHCARE

Child's Physician: _____ Phone: _____

Address: _____

Child's Dentist: _____ Phone: _____

Address: _____

AUTHORIZED ADULTS: In the event of an emergency, please indicate your name and phone number where YOU ***and*** another authorized person can be reached:

Mother's name: _____ Phone: _____

Father's name: _____ Phone: _____

Another authorized person's name: _____

Phone: _____ Address: _____

FIRST AID:

In the event of an emergency, I authorize staff to provide any first aid care deemed necessary for my child.

_____

Signature Date

EMERGENCY CARE

In the event of an emergency in which I cannot be reached, the physician listed above and the local hospital are hereby authorized to provide any emergency care deemed necessary for my child.

_____

Signature Date

First Presbyterian Preschool

PERSONAL HISTORY

My child is: ☐ right-handed ☐ left-handed

Has child had a previous group or preschool experience? ☐ Yes ☐ No

If yes, list where and when: _____

Does child have any allergies? ☐ Yes ☐ No

If yes, list allergies: _____

Are there any medical problems? ☐ Yes ☐ No

If yes, list: _____

What word does the child use for toileting? _____

Does child have any bowel or bladder irregularities? ☐ Yes ☐ No

If yes, list: _____

Is there any special food or eating instructions? ☐ Yes ☐ No

If yes, list: _____

If there is any additional information you would like us to know such as discipline, communication, comforting, etc., please list:

_____

_____

_____

_____

_____

First Presbyterian Preschool

HEALTH FORM

Child's Name: _____ DOB: _____

Child's home address: _____

Child's height: _____ Child's weight: _____

What contagious diseases has the child had?

☐ Measles ☐ Mumps ☐ Rheumatic Fever ☐ Scarlet Fever ☐ Whooping Cough ☐ Chicken Pox

Other: _____

Child is subject to: ☐ Wetting accidents ☐ Nosebleeds ☐ Hearing Loss

Does the child wear glasses? ☐ Yes ☐ No

List any additional information on the following: Allergies, toilet habits, sleep and nap habits, eating habits, behavior habits (such as biting nails, thumb sucking, tantrums, biting, etc,):

_____

_____

Any handicaps? ☐ Yes ☐ No If Yes, please explain: _____

_____

Required immunizations (please provide dates): DPT or Diphtheria:_____

Chicken Pox _____ Mumps:_____ Tetanus:_____ Whooping Cough: _____

Polio:_____ Measles:_____ German Measles (Rubella): _____

To be filled in by physician: Are all immunizations up to date? ☐ Yes ☐ No

If there is a medical reason why immunization should not be given, please explain:

_____

_____

_____

Physician's signature Date