St. Philip Lutheran Preschool
7304 Falls of Neuse Road 27615

Name_________________________________ Date of Birth___________

Please **CIRCLE** the class in which you wish to enroll: (birthday cut-off August 31)

2 year class – Tuesday & Thursday
2 year class – Wednesday & Friday
3 year class – Tuesday & Thursday
3 year class – Monday, Wednesday, Friday
4 year class – Monday, Tuesday, Thursday
4 year class – Monday, Wednesday, Friday
4 year class – Monday – Friday
(2,3,4 year classes 9:00-12:00)
Kindergarten – Monday - Friday
(9:00-1:00 Mon-Thur & 9:00-12:00 Fri)

Parents' Name____
Address____
Home Telephone____________________Business____________________
Church Preference ____
Church Address____

GENERAL INFORMATION

A registration fee of one month's tuition must accompany this form. THIS FEE IS NON-REFUNDABLE. When the form is returned to school, your child will be placed on a class roll. A letter of acceptance will be mailed to you in JULY. Parents may contact the Director to confirm a place in a class as soon as the forms have been returned.

Tuition is paid monthly due on the 15th of each month. The first month's tuition is due on August 15th and the 15th of each subsequent month with the final payment due April 15th.

TUITION SCHEDULE

2 day classes	$170
3 day classes	$225
5 day class	$275
Kindergarten	$295

If you have any questions about enrollment or the program, please contact the Director at 870-5841 0r 848-8844.

Date____________________

Application for____
last first middle name uses

Date of Birth__________________Sex_________Phone______________________

Address____

Father's
Name_________________________________Bus/CellPhone__________________

Occupation & Address____

Mother's
Name__________________________________Bus/CellPhone_________________

Occupation & Address____

Siblings (names & ages)____

Other adults in the home____

Language other than English used in the home____________________________

Previous schools attended____

IN CASE OF EMERGENCY – Responsible party to call if parent cannot be reached.
Name____________________________________Phone_____________________

IN CASE OF MEDICAL EMERGENCY
Physician_________________________________Phone_____________________

Any concerns about your child's general health?___________________________

Explain any speech problem.____

Problems with toilet habits? ____
(must be potty trained before coming to the 3 year class)

Any unusual fears? ____

Excessive jealousy? ____

Nail biting, thumb sucking, etc? ____

Have trouble handling anger?____

Does your child use one hand in preference to the other?___________________

With whom does your child usually play? _______________________________

___

Is there any additional information about your child, which might help the teachers in working with your child? ___________________________________

____

___

___

Do you have any concerns about your child's behavior or emotional well-being that the teachers should be aware of? __________________________________

___

___

___

What are your goals and expectations for your child in the coming year? _______

___

___

___

___

Parent Signature____

Date received ______________________Registration Paid_________________

MEDICAL INFORMATION

Child's Name ____________________________________Birth Date________

Parents____
Address____
History:
Allergies_________ChickenPox_________Measles_________Mumps________

Whooping Cough ________Rheumatic Fever __________Diabetes___________

Epilepsy ___________Tuberculosis __________ Asthma___________________

Chronic Colds ________Chronic Sore Throats ________ Chronic Ear

Infections_________ Nosebleeds__________ Drug Sensitivities _____________

PX: Head __________
Heart__________
Eyes __________
Ears __________
Nose __________
Mouth _________
Extremities _____

Abdomen___________
Lungs _____________
Vision _____________
Hearing ____________
Adenoids___________
Tonsils ____________

Record of Immunization:

	1st dose	2nd dose	3rd dose	4th dose
DTaP	_________	_________	_________	__________
Polio	_________	_________	_________	__________
MMR	_________	__________		
Hib	_________	_________	_________	
Hep B	_________	_________	_________	
Varivax	________			

Do you recommend this child for Preschool? YES ________ NO _______
Are there any medical conditions, operations, accidents that we should be aware of?____

Physician's Signature ________________________________Date__________