

# Application for Enrollment

## St. Peter's Episcopal Preschool

925 Mitchell St. Conway, AR 72034

Please return completed application with \$40 non-refundable registration fee\*  
to St. Peter's Episcopal Preschool.

\*Fee waived for church members

Today's Date \_\_\_\_\_

Your Child's Name \_\_\_\_\_

First - Middle - Last

Preferred Name ("goes by"?) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Who has legal guardianship of the child? \_\_\_\_\_

Guardian's Name/s \_\_\_\_\_

Home Address (street) \_\_\_\_\_

City - State - Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

### Mother's/Guardian's Information

Occupation/Employer \_\_\_\_\_

Work Phone/Cell Phone \_\_\_\_\_

Hours \_\_\_\_\_

### Father's/Guardian's Information

Occupation/ Employer \_\_\_\_\_

Work Phone/ Cell Phone \_\_\_\_\_

Hours \_\_\_\_\_



### Emergency Contact Information

Name of person to call if parents cannot be reached \_\_\_\_\_

Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is this person authorized to take your child from the preschool? \_\_\_\_\_

List all other adults authorized to take your child from the center (attach another page, if needed):

_____	_____	_____	_____
Name	Relationship	Name	Relationship

_____	_____
Address	Address

_____	_____	_____	_____	_____	
City	State	Zip	City	State	Zip

_____	_____
Telephone	Telephone

_____	_____
Driver's License Number	Driver's License Number



### Medical Information

Your child's physician or emergency treatment facility \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Telephone \_\_\_\_\_

I, \_\_\_\_\_ Mother, Father, Guardian (CIRCLE WORD THAT APPLIES) of \_\_\_\_\_ (Child's Name) do hereby give my consent to the Director of St. Peter's Episcopal Preschool, or her/his duly appointed representative, for said child to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parents cannot be reached. Consent is also given for the Director or her/his duly appointed representative to transport said child for emergency medical treatment, if the parents cannot be reached.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date



### Immunizations

Please provide a copy of your child's Immunization Record

Verified by Health Department Record \_\_\_\_\_ Physician's Record \_\_\_\_\_ Other \_\_\_\_\_



### Medical History

Measles \_\_\_\_\_ Mumps \_\_\_\_\_ German measles \_\_\_\_\_ Chicken pox \_\_\_\_\_  
Date Date Date Date

Whooping Cough \_\_\_\_\_ Contracted Tuberculosis: Yes \_\_\_/No \_\_\_  
Date

Frequent Ear Infections: Yes \_\_\_/No \_\_\_ Frequent Throat Infections: Yes \_\_\_/No \_\_\_

Heart defects: Yes \_\_\_/No \_\_\_

Other conditions or comments (attach another page, if needed.)

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### Your Child's Developmental Needs

My child requires help in: Dressing \_\_\_\_\_ Undressing \_\_\_\_\_ Toileting \_\_\_\_\_

Eating \_\_\_\_\_ Washing hands \_\_\_\_\_

Is your child toilet trained? Yes \_\_\_\_\_ No \_\_\_\_\_ Words used in toileting \_\_\_\_\_

Favorite games, toys and foods \_\_\_\_\_

\_\_\_\_\_

Type of childcare used previously \_\_\_\_\_

Physical or emotional challenges your child might have \_\_\_\_\_

\_\_\_\_\_

Your child's special food needs: Formula \_\_\_\_\_ Diabetic diet \_\_\_\_\_

Allergies \_\_\_\_\_

Special issues: Temper tantrums \_\_\_\_\_ Diabetes \_\_\_\_\_

Frequent colds \_\_\_\_\_ Biting \_\_\_\_\_ Sun Sensitivity \_\_\_\_\_

Seizures \_\_\_\_\_ Fainting spells \_\_\_\_\_ Bed wetting \_\_\_\_\_

Other useful information (continues on next page)

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Applying for which Program?

Monday through Friday

With nap \$325

Without nap, noon pickup \$250

Monday, Wednesday, Friday

With nap \$210

Without nap, noon pickup \$165

Tuesday, Thursday

With nap \$160

Without nap, noon pickup \$130



I, the parent/guardian of this child, understand that I may ask for a conference with the caregiver(s) as needed.

Signature \_\_\_\_\_

Date \_\_\_\_\_

We are required to keep a copy of the child's immunizations on file. Please bring your record, and we will make a copy here.

Please tell us how you learned of our preschool.

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For Office Use Only

Date Received \_\_\_\_\_

Class \_\_\_\_\_

Date Paid \_\_\_\_\_

Date Registration Packet Sent \_\_\_\_\_