

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.)



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)



Applying for which Program?

Monday-- Wednesday - Friday 8:30 - 12:00 _____ \$133/month

Tuesday - Thursday 8:30 - 12:00 _____ \$111/month

Monday through Friday _____ \$195/month

“Stay and Play” Extended Care 12:00 - 2:30 (circle day/s)

available Mon.-Tues. -Wed.-Thurs. : additional \$10/month for each extended day.



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.

For Office Use Only

Date Received _____

Class _____

Date Paid _____

Date Registration Packet Sent _____