

Date _____

Registration Fee _____

**South Gate Preschool
Registration Form 2017-2018**

Child's Name _____ Nickname _____

Birthday (month/day/year) _____ Gender: M/F

Home Address _____ City/zip _____

Parent information

Mother _____ Occupation _____

Home phone _____ Cell Phone _____ Work Phone _____

Father _____ Occupation _____

Home phone _____ Cell Phone _____ Work Phone _____

Marital Status: () Married () Separated () Divorced () Unmarried

Siblings: Name _____ age _____

Name _____ age _____

Name _____ age _____

Left Handed _____ Right Hand _____

Class Preference:

The following options are for children 4 and 5 years old. Children attending these classes must be four years old by July 31st. If your child turns four between July 31st and October 15th, please contact us about entrance into this class.

Children may be **DROPPED** off between 8:45 and 9:00 a.m.

_____ Monday-Wednesday-Friday 9:00 – 11:30 a.m. \$130.00 per month

_____ Monday – Friday a.m. 9:00 – 11:30 a.m. \$230.00 per month

Please note....
Sessions are subject to change if minimum enrollment is not met.

The following option is for 3 year olds. Children attending this class must be three years old by July 31st.

_____ Tuesday/Thursday a.m. 9:00 – 11:30 a.m. \$110.00

Registration Fee: \$50.00 for first child. \$25.00 for each additional child from the same family.

Registration Fee is NON – REFUNDABLE

Local Emergency Contacts (other than parents. Must include 2)

Name _____

Name _____

Address _____

Address _____

Cell # _____ Home # _____

Cell # _____ Home # _____

Relationship to Child _____

Relationship to Child _____

Persons permitted to pick up your child

Persons listed will need to show a valid driver's license before child will be released.

Name _____

Name _____

Cell # _____ Home # _____

Cell # _____ Home # _____

Relationship to Child _____

Relationship to Child _____

Neighborhood Walks

I hereby give South Gate Preschool permission to take my child on a walk around the preschool Neighborhood.

Signature of Parent/Guardian

Date

Consent to Contact Physician in an Emergency

In the event that I cannot be reached to make arrangements, I hereby give my consent to South Gate Preschool to Contact:

Name of Physician _____ Phone _____

Address _____ City _____ zip _____

And if necessary, call emergency personal. I prefer my child be taking to _____
Hospital

Signature of Parent/Guardian

Date

Child's Medical Information

Current Health status or any health problems caregiver should know? _____

Special Diets

Does your child require a modified diet or have an intolerance to food _____ No _____ Yes

If yes, please explain/details: _____

Allergies _____ No _____ Yes If yes, please explain/details:

Allergic to _____ Reaction _____

Allergic to _____ Reaction _____

Comments _____

_____ +

I understand that if my child is allergic to anything or has an intolerance to food, my child's information will be posted in his/her classroom. This posting are informational and intended to provide safety for my child.

Special concerns: (Glasses, Hearing Aids, Speech) _____

Any activities Child should NOT engage in: _____

I certify that the above information is correct to the best of my knowledge.

Signature of Parent/Guardian

Date

Immunization Records

In order for children to attend South Gate Preschool and Children's Day Out we require that ALL children are current with their immunizations. The Lancaster County Health Department require us to maintain current documentation of each child's immunization records. We **MUST** have a copy of your child's immunizations before they begin Preschool or CDO.

<u>First Name:</u>		<u>Last Name:</u>		<u>Date of Birth:</u>		
PCV 1 / /	DTaP 1 / /	IPV 1 / /	HIB 1 / /	HEP-B 1 / /	MMR 1 / /	VAR 1 / /
PCV 2 / /	DTaP 2 / /	IPV 2 / /	HIB 2 / /	HEP-B 2 / /	MMR 2 / /	VAR 2 / /
PCV 3 / /	DTaP 3 / /	IPV 3 / /	HIB 3 / /	HEP-B 3 / /		
PCV 4 / /	DTaP 4 / /	IPV 4 / /	HIB 4 / /			
	DTaP 5 / /					

PCV – Includes PCV7 or 13, (Prevnar) and PPV23

DTaP – Includes DtaP and DTP (Diphtheria, Tetanus, Pertussis)
DT (Diphtheria, Tetanus – Pediatric)
Td (Tetanus, Diphtheria – Adult)

IPV – Includes OPV (Oral Polio Vaccine)
IPV (injectable Polio Vaccine)

HIB – Haemophilus Influenzae Type B

Hep B – Hepatitis B

MMR – Measles, Mumps, Rubella

VAR – Varicella VZV

I certify that the above information is correct to the best of my knowledge.

Signature of Parent/Guardian

Date