

TRINITY TOWER PRESCHOOL

2010

REGISTRATION/EMERGENCY CARE FORM

2011

3-Day, 4- Year Old Class
 Monday, Wednesday, Friday
 9:30 a.m. to 11:45 a.m.

Child's Name _____
_(Last Name, First Name, MI) Nickname

Birthdate _____ Age on September 1, 2010 _____

Address _____ Telephone Number _____

_____ Zip Code _____ Sex: M F

FAMILY

Father

Mother

Name _____

Occupation _____

Place of Employment _____

Business Phone Number _____

Number of Brothers: Older Younger
 Number of Sisters: Older Younger

IMMUNIZATIONS ARE LISTED ALONG WITH SUGGESTED AGES. PLEASE LIST DATES

Health Assessment	Birth	1-2 Mo.	2 Mo.	4 Mo.	6 Mo.	6-18 Mo.	12-15 mo.	15-18 mo.	4-6 Yrs.
Diphtheria, Tetanus (DTP), Whooping Cough									
Measles, mumps, German measles (MMR)									
Polio									
Hib (Haemophilis influenza type b)									
Hepatitis B									
Varicella (Chicken Pox)									

Has your child ever been diagnosed with any eye problems? No Yes If Yes, please explain: _____

Does this child wear glasses (corrective lens)? No Yes

Has your child ever been diagnosed with a hearing problem? No Yes If Yes, please explain: _____

Should this child have restrictions in play or physical activities? No Yes If "Yes", please explain: _____

Does this child have any allergies? No Yes If "Yes", please list and include medication, food, environmental, etc.: _____

Does this child take any medication(s) on a daily or regular basis? No Yes If Yes, please list and include medication, food, environmental, etc. _____

Does this child have any unusual health conditions/problems that Trinity Tower Preschool should know about? (Diabetes, asthma, heart defect, ADHD, etc.)
 No Yes If "Yes", please explain: _____

The following information must be furnished to help the school obtain the best first aid and emergency care for your child in the event of injury or sudden illness:

If parent(s) cannot be located, please notify: _____
(Name)

Relationship to child _____

Address _____ Phone No. _____

_____ Zip Code _____

I have authorized this person to direct or to obtain the necessary emergency care for my child. (Be sure this person has been consulted beforehand and is willing to give this assistance in case of an emergency.)

When the parent(s) and the individual named above are not available and it is necessary to call the child's physician or dentist, please contact:

Physician's Name _____ Phone No. _____

Address _____ Location _____
(City, Borough, Township, etc.)

Dentist's Name _____ Phone No. _____

Address _____ Location _____
(City, Borough, Township, etc.)

In the event that the child's doctor(s) are also not available, I expect the Trinity Tower Preschool to obtain the best first aid, emergency care or physician's services as may be considered appropriate or necessary. I request that my child be taken by ordinary transportation or ambulance as may be appropriate or necessary for emergency care.

Tuition for Trinity Tower Preschool is on a monthly basis. The first month's tuition payment is due on July 1, 2010. All tuition payments for succeeding months are due by the first of the month. Payments received postmarked on or after the 5th of the month will be subject to a late fee of \$10.00. Any child whose tuition has elapsed for two months will be dropped from the roll. Please refer to the Trinity Tower Preschool *Parents' Handbook* for additional information. Trinity Tower Preschool reserves the right to change tuition costs **if** a need arises during the current school year.

DAILY TRANSPORTATION INFORMATION

My child: ___ Will be riding to school with his/her parent(s).
___ Will be riding in a carpool with the following person(s) _____
___ Will be walking to school.

Today's Date

(Signature of Parent or Guardian)