

2017

TRINITY TOWER PRESCHOOL REGISTRATION/EMERGENCY CARE FORM

2018

2- Day, 3 Year Old Class
Monday and Wednesday
9:30am to 12:00pm

Child's Name _____

Birthdate _____ Age on September 1, 2017 _____ 3 _____

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

**PLEASE ATTACH YOUR CHILD'S CURRENT IMMUNIZATION RECORDS.
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 problem? ___ 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, 2017. All tuition payments for succeeding months are due by the first of the month. Payments received postmarked after the 5th of the month will be subject to a late fee of \$10.00. **Any child whose tuition has lapsed for two months will be dropped from the class roster.** 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. Trinity Tower Preschool reserves the right to suspend operations **if** a mandatory enrollment is not achieved.

DAILY TRANSPORTATION INFORMATION

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

I attest that the information provided on this registration form is accurate. I understand the terms of tuition payments stated above and agree to all terms.

Today's Date

Signature of Parent or Guardian