St. John's Evangelical Lutheran Church Preschool
Boyertown, PA 19512

Four Year Old
APPLICATION

3 days AM (Mon., Wed., Thur.)	**9:00 – 11:30**	**$110/month**
3 days PM (Mon., Wed., Thur.)	**12:30 – 3:00**	**$110/month**
4 days AM (Mon., Tue., Wed., Thur.) ****needs 14 children to hold**	**9:00 – 11:30**	**$150/month**

Name of Child:

_____

LAST FIRST MIDDLE

Date of Birth:_____ Place of Birth:_____

Street Address_____ M_____F_____

Town & State:_____ Home Phone:_____

Child Lives With:_____

Father:

Name:_____ Birthdate:_____

Education:_____Occupation:_____

Place of Employment: _____Phone:_____

Church Membership_____

Mother:

Name:_____ Birthdate:_____

Education:_____Occupation:_____

Place of Employment: _____Phone:_____

Church Membership_____

Brothers and Sisters:

Name Birthdate Grade in School

_____

_____

_____

_____

What do you hope your child will gain from this experience?_____

_____

_____

Describe your child including any special problems of which the staff should be aware:

_____

_____

_____

Experience with other children:

Previous school experience_____

Sunday Church School_____

Informal Relationships_____

How did you hear about St. John's?_____

E-Mail Address (To be used for billing and parent blasts)—please write clearly

_____

MEDICAL INFORMATION:

HEALTH RECORD—TO BE FILLED OUT AND SIGNED BY DOCTOR

Name of Child:_____Birthdate:_____

Height:_____Weight:_____

Immunization Record: Please attach

Medicine Child is Taking:_____

Child's Outstanding Medical History: (i.e. Diabetes, Heart Disease, etc.)_____

_____

Child's Allergies: (if any)_____

Childhood Diseases and Illnesses:_____

_____

Health Problems or Disabilities:_____

_____

Emotional Problems or Fears:_____

_____

Recommendations:_____

Name of Child's Doctor: _____ **Telephone Number**:_____

Doctor's Signature:_____

Address:_____

_____

MEDICAL INSURANCE INFORMATION

Insurance Company: _____Policy Number:_____

Subscriber's Name:_____

Subscriber's Place of Employment:_____

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I, _____, hereby authorize any and all medical attention deemed necessary for my child, _____, in the event of an accident, injury, or sickness, under the direction of the bearer of this form, until such time as I may be contacted. This authorization is effective until revoked by me and I hereby assume the responsibility for the payment of such treatment.

_____

Name of local person, other than parents or guardian, who we may contact in the event of an emergency:

Name:_____Phone:_____

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SIGNATURES OF PARENT(S)/GUARDIANS

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Application fee (non-refundable) of $45.00 ($40.00 prior to 3/15/2018) must accompany this form.

Health record page must be submitted prior to August 31st in order for child to begin school.

In making application for my child, _____to be enrolled in St. John's Preschool, I/We also give permission for his/her participation in short trips or walks. I/We understand that St. John's Evangelical Lutheran Church and its staff involved in the activity are not responsible in the event of accident or illness. I/WE also agree that St. John's may display, on our website or Facebook page, photos of your child during activities.

Signatures: Father:_____Date:_____

Mother:_____Date:_____