

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

Transitional Kindergarten
APPLICATION

Mon., Tue., Wed., Thur., Fri.	9:00 - 11:30	\$200/month
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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: _____

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:** _____

SIGNATURES OF PARENT(S)/GUARDIANS

Application fee (non-refundable) of \$45.00 (\$40.00 prior to 3/15/2019) 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 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:** _____