

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

Two Year Old Play Group  
**APPLICATION**

Mon. & Wed.	8:45 - 10:15	\$70/month
Mon. & Wed.	10:30 - 12:00	\$70/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

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

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

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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**

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**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 3/15/2019) must accompany this form.**

**Health record page must be submitted prior to August 31<sup>st</sup> 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:** \_\_\_\_\_