All God's Children Preschool

Registration Information 2010-2011

Registration Dates and Procedures

- Priority registration for current families, alumni families, church & school staff, and church members is **February 8-12.**
- Open registration is **February 15-19.** All persons new to the school must schedule a tour before registering. Please call the school office (704)788-6315 to arrange a visit. You may register on the day of your visit.
- Registration fees are due with the application to hold your child's spot.
- Once classes are filled, any persons interested in registering their children will be placed on a waiting list.
- Health forms and Immunization records, included with your application, must be completed by your physician and returned to the school office by August 31st. Your child may not attend preschool until these forms are on file.

Registration Fees:		
	Church Members	$55
	Non-Church Members	$65
	Family Registration (Two or more children)	$100

Registration Fees are non-refundable

Following Cabarrus Co. Kindergarten entrance dates - Age cut-off for each class is August 31st – NO Exceptions

All classes are 9:00 am – 1:00 pm

Classes Available:	*Time*	*Price*
❐ Ones	M-F	300.00
❐ Ones	MWF	185.00
❐ Ones	TTh	140.00
❐ Twos	M-F	284.00
❐ Twos	MWF	183.00
❐ Twos	TTh	132.00
❐ Threes & Fours	M-F	266.00
❐ Threes & Fours	MWF	170.00
❐ Threes & Fours	TTh	122.00
❐ TK (Transitional Kindergarten)	M-F	231.00

3101 Davidson Highway Concord, NC 28027
704-788-6315 Phone
704-721-5783 Fax

Class ___________
___Tuesday, Thursday
___Mon-Wed.-Fri.
___Monday – Friday

Application date ____
Deposit ____
Email address ____

All God's Children Preschool

Application for Child Care

Child's Name ____
Last First Middle Preferred name

DOB__________ Male ( ) Female ( ) Home Phone ______________________________

Address ____

Father (Guardian) Name ____
Address ____ Cell Phone ______________________________
Employer____ Work Phone _____________________________

Mother (Guardian) Name ____
Address ____ Cell Phone ______________________________
Employer____ Work Phone _____________________________

Insurance Carrier ____ **Policy Number** _________________________

Information about your child

Does your child have any known allergies? Yes ( ) No ( ) If yes, please explain, ____________________________

Please explain any information concerning your child which will be helpful in his/her experience in a group setting (such as play, eating & sleeping habits, special fears, special likes or dislikes) ____

Emergency Care Information

Name of child's doctor____ Phone ______________________________
Address ____
Name of child's dentist ____ Phone ______________________________
Address ____
Hospital preference ____

If neither parent/guardian can be contacted, please call:
Name ____ Phone ______________________ ( ) Okay to pick up
Relationship to Child ____
Name ____ Phone ______________________ ( ) Okay to pick up
Relationship to Child ____

I agree that the operator may authorize the physician of his/her choice to provide emergency care in the event that neither I nor the family physician can be contacted immediately.

Parent Signature ____ Date ________________

I as the operator, do agree to provide transportation to an appropriate medical resource in the event of an emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian. Provisions will be made for adequate and appropriate rest and outdoor play.

Signature of Operator ____ Date ________________

Children's Medical Report

Name of Child____Birthdate _____________________

Name of Parent or Guardian ____

Address of Parent of Guardian ____

A. Medical History (May be completed by parent)

1. Is child allergic to anything? No___ Yes___ If yes, what?____
____
2. Is child currently under a doctor's care? No___ Yes___ If yes, for what reason?_______________________
____
3. Is the child on any continuous medication? No___ Yes___ If yes, what?____________________________
____
4. Any previous hospitalizations or operations? No___ Yes___ If yes, when and for what?_______________
____
5. Any history of significant previous diseases or recurrent illness? No___ Yes___ ;
   diabetes No___Yes___; convulsions No___ Yes___; heart trouble No___ Yes___.
   If others, what/when?____
6. Does the child have any physical disabilities: No___ Yes___ If yes, please describe:________________
____

Any mental disabilities? No___ Yes___ If yes, please describe:____________________________________

Signature of Parent or Guardian____**Date**___________

B. Physical Examination: This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the N. C. Board of Medical Examiners (or a comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting DEHNR standards for EPSDT program.
Height _________% Weight __________%

Head____________ Eyes_____________ Ears_____________ Nose___________ Teeth_______

Throat__________ Neck_________ Heart_________Chest_________Abd/GU_______________

Ext__________Neurological System_____________________________Skin__________________

Results of Tuberculin Test, if given: Type__________date__________ Normal___Abnormal___________
Should activities be limited? No___ Yes___ If yes, explain: ____
Any other recommendations: ____

____ Date of
____ Examination__________

Signature of authorized examiner/title____________________________________**Phone #**_______________

Immunization History

Name: ______________________________ **Date of Birth:** ____________________

Enter the date an immunization was received in the space below or attach a copy of the immunization record. G.S. 130A-155(b) requires all child care facilities to have this information on file.

Enter date of each dose - Month/Day/Year

VACCINE	#1	#2	#3	#4	#5
*DTP / DT (circle which)					
*Polio					
**Hib					
***Hepatitis B					
*MMR (combined doses)					
OTHER ____________					
OTHER ____________					

* Required by State law.
** Required by State law for children born on or after 10/1/88.
*** Required by State law for children born on or after 7/1/94.

Records Updated by:	Date Updated:

DCD-0109
3/00