

Beulah Methodist Preschool 2012 – 2013 Registration Form

161 Beulah Church Road, Gilbert, SC 29054 * (803) 892-3793 * BeulahPreschool@pbtcomm.net

Please place a checkmark by the class(es) in which you wish to enroll your child:

* Child must attain the age below before September 1, 2012

- 2 year old class Monday & Wednesday** Tuition: \$100 per month Registration Fee: \$100
- 2 year old class Tuesday & Thursday** Tuition: \$100 per month Registration Fee: \$100
- 3 year old class Monday & Wednesday** Tuition: \$85 per month Registration Fee: \$85
- 3 year old class Tuesday & Thursday** Tuition: \$85 per month Registration Fee: \$85
- 4 year old class Monday – Thursday** Tuition: \$160 per month Registration Fee: \$160
- 3 year old Fun Friday (optional)** Tuition: \$50 per month Registration Fee: \$50
- 4 year old Fun Friday (optional)** Tuition: \$50 per month Registration Fee: \$50

Student Information:

Name: _____
First Middle Last Name Called

Street: _____

City: _____ State: SC Zip code: _____

Home Phone: _____ Student's Date of Birth: _____ Gender: _____

Mother's Name: _____

Employer: _____ Work phone: _____

Employer's Address: _____ Cell phone: _____

E-mail: _____

Father's Name: _____

Employer: _____ Work phone: _____

Employer's Address: _____ Cell phone: _____

E-mail: _____

Persons who have permission to sign out student (other than parents):

Name: _____ Relationship to student: _____

Address: _____

Phone: _____ Cell phone: _____

Name: _____ Relationship to student: _____

Address: _____

Phone: _____ Cell phone: _____

Name: _____ Relationship to student: _____

Address: _____

Phone: _____ Cell phone: _____

If parents cannot be reached in case of an emergency, please call:

Emergency Contact:

Name: _____ Relationship to student: _____

Phone: _____ Cell phone: _____

Emergency Contact:

Name: _____

Relationship to student: _____

Phone: _____

Cell phone: _____

Medical Information

Physician's Name: _____

Address: _____ Phone: _____

Preferred hospital: _____

Special Medical Emergency Instructions:

In a medical emergency, do we have your permission to take your child to Lexington Medical Center for treatment or to call your family doctor or other doctor and will you be responsible for the expenses involved?

Yes

No

Signature: _____

Date: _____

Health History – Please check and explain in the area provided:

Food allergies

Please list: _____

Asthma

Chicken Pox

Frequent ear infections

Diabetes

Frequent stomachaches

Epilepsy

Frequent headaches

Hyperactivity

Other: _____, please explain:

Is emergency treatment needed for insect bites? **YES** **NO**

Please describe treatment: _____

Does child have special medical problems? **YES** **NO**

Please describe: _____

Does child have any serious illnesses? **YES** **NO**

Please describe: _____

Does your child cry easily? **YES** **NO**

Does your child have unusual fears? **YES** **NO**

Please describe:

Does your child have separation anxiety? **YES** **NO**

Is your child shy? **YES** **NO**

Does your child have tantrums? **YES** **NO**

Does your child bite others? **YES** **NO**

Can your child manage clothes and bathroom needs? **YES** **NO**

Are parents: Married Divorced Separated Widowed

Please give any special instructions which you feel may help the preschool staff work better with your child.
