

## Zoar Lutheran Preschool Registration Form

**Due with Registration: \$100 (Includes Registration & Materials)**

(\$50 is refundable if a student is withdrawn prior to July 1, 2020 and request is submitted prior to that date)

Class (3's am, 4's am): \_\_\_\_\_

This information is for the teachers' use only and will be treated as confidential.

Child's Full Name: \_\_\_\_\_

Nickname: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ Phone:(h)\_\_\_\_\_ (w)\_\_\_\_\_

\_\_\_\_\_ E-mail address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ Phone:(h)\_\_\_\_\_ (w)\_\_\_\_\_

\_\_\_\_\_ E-mail address: \_\_\_\_\_

Parent to notify in case of emergency:

\_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

Alternate emergency contacts:

\_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

Child's Physician:

\_\_\_\_\_ Phone: \_\_\_\_\_

Who may pick up child? Mother \_\_\_\_\_ Father \_\_\_\_\_

Others: \_\_\_\_\_ (relationship) \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ (relationship) \_\_\_\_\_ Phone: \_\_\_\_\_

*Zoar Lutheran Preschool does not discriminate on the basis of race, color, national origin, or ethnic origin.*

*rev January 24 2020*

## Parental Agreement

I understand that Zoar Lutheran Preschool is a non-profit organization dependent on each parent's involvement, participation, financial support and administration in partnership with the teacher for its educational effectiveness.

We share the responsibilities for belonging by:

Attending all parent meetings when scheduled.

Paying a one time non-refundable enrollment fee of \$100 due at the time of registration to hold spot in class.

Supporting fundraising activities as chaired by the Preschool Board; (these fundraisers are essential to the continued operation of the school).

Paying tuition no later than the 10<sup>th</sup> of each month.

Having your child immunized for DPT, Polio, TB, Hib, Rubella, Varicella as mandated by the Oregon State Health Division, and show documentation of such. (Forms available)

Giving 30 days written notice of withdrawal from school. This will be waived in cases of true medical emergency.

Refer to the handbook for more specific details of the above responsibilities.

I have read and understand the above conditions for registration of my child

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Child's Name

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Class (3's/4's)

Signed: \_\_\_\_\_  
Parent/Legal Guardian

Date: \_\_\_\_\_

## Consent for Medical Treatment

Complete this Consent for Medical Treatment form.  
This form authorizes treatment for your child in your absence.

Child's Full Name: \_\_\_\_\_ Age: \_\_\_\_\_

I hereby authorize the Zoar Lutheran Preschool staff, who is eighteen years of age or older, to seek any medical or surgical treatment of the above child that such staff deems advisable if a parent or legal guardian cannot be reasonably located when my child is taken for treatment at any hospital or clinic.

The above authorization will be effective as of \_\_\_\_\_ and will expire after \_\_\_\_\_.

During this period, the parent/legal guardian of the above child can be contacted at:

Name: \_\_\_\_\_ Phone (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_

Name: \_\_\_\_\_ Phone (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Name of Primary Insured: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Child's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Chronic Illnesses or Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Legal Guardian

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## School Permission Form

I hereby give my permission for my child, \_\_\_\_\_, age \_\_\_\_\_, to use all of the play equipment and participate in all of the activities of the school unless otherwise noted below.

I give permission for my child to leave the school premises under the supervision of a staff member or volunteer for neighborhood walks (parents will be notified in advance).

I give permission for my child to be included in photos/video on our website or connected with school programs.

I give permission for the teacher or other staff member to take whatever steps necessary to obtain emergency medical care if warranted in the opinion of the teacher.

These steps may include, but are not limited to:

1. Attempt to contact parent/guardian.
2. Attempt to contact child's physician, as designated on "Consent for Medical Treatment" form.
3. In the event a parent or guardian or child's physician cannot be contacted, we will do any of the following:
  - A. Call another physician.
  - B. Call an ambulance.
  - C. Have the child taken to an emergency hospital room in the company of a staff member.
4. Any expenses incurred by the above action will be the responsibility of the child's family.
5. The school cannot be responsible for anything that may happen as a result of false information, or lack of information given at the time of enrollment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian

This information is for the teachers' use only and will be treated as confidential.

Child's Name: \_\_\_\_\_

Nickname: \_\_\_\_\_

Allergies: \_\_\_\_\_

Siblings' names and ages: \_\_\_\_\_

Eating Habits: \_\_\_\_\_

Reaction to minor injuries: \_\_\_\_\_

Pets and Names: \_\_\_\_\_

Fears: \_\_\_\_\_

Discipline tips for your child: \_\_\_\_\_

\_\_\_\_\_

Home Church (if applicable): \_\_\_\_\_

Any other information the teacher should know about your child: \_\_\_\_\_

\_\_\_\_\_