Lexington United Methodist Preschool Registration Form
2019-2020

Number _____________ Check #_____________ Date________________

Church member____________________ Sibling Discount______________

Child's Name____________________________ Likes to be called___________________

Home Address____________________________ Male/Female_______________________

____ Birth Date_________________________

Email Address____________________________

Home phone #____________________________ Age on September 1, 2019___________

Mother's Name___________________________ Cell Phone________________________
Business_______________________________ Work Phone________________________
Father's Name___________________________ Cell Phone________________________
Business_______________________________ Work Phone________________________

Other children in family (Names and Ages)____
____
____

Does child currently reside with both parents?__ If no, please explain, including information about who cannot pick up this child. (Use back)

Is there any additional information that might be important for us to know in our relationship with your child? (use back, if needed)

I am interested in:

One's Program	□ Monday and Wednesday □ Tuesday and Thursday
Two's Program	□ Monday and Wednesday □ Tuesday and Thursday
Two & 1/2's Program (age 2 by March 1st)	□ Tuesday, Wednesday & Thursdays
Three's Program	□ Monday, Wednesday, & Friday □ Tuesday and Thursday
Four's Program	□ Monday thru Thursday (4days) □ Monday thru Friday (5 days)

Medical Information:

Physician's Name____

Address ____ Phone Number ________________________

Child's Insurance: ____________________________________ Policy #___________________________

Insured Name____

In the event that I or others listed above are not available, I give my permission to the LUMC Preschool to provide first aid for the child named above and to take the appropriate measures, including contacting the Emergency Medical Services (EMS) system and arranging for transportation to the nearest hospital/emergency medical facility. At no time will the caregiver drive an ill or injured child to an emergency medical facility unless accompanied by another adult. I am also aware that in some instances immediate medical attention is necessary. If I cannot be contacted, the staff has my permission to use their judgment in such matters.

______________yes ______________no

Parent or Guardian Signature____

Date_____________

History Health: Please check any medical conditions your child may have and explain details in the provided area.

Food Allergies:

Please List:

Does your child an EPI pen? Yes or No If you answered yes, the parent or guardian will need to supple a pen to keep in the Preschool Directors office under lock and key.

Asthma_________________ Chicken Pox__________________ Diabetes______________

Frequent Ear Infections__________ Epilepsy___________________ Hyperactivity___________

Frequent Headaches____________ Frequent Stomach aches______________ Peanut allergy__________

Diary allergy_______________ Other__________________ (please explain)

Other: please circle yes or no and feel free to add any addition information if needed!

Does your child cry easily? Yes or No
Does your child have separation anxiety? Yes or No
Is your child shy? Yes or No
Does your child have tantrums? Yes or No
Does your child bite? Yes or No

Parents Relationship: ___married _____divorced _____separated _______widowed ___________other

Does your family have a home church? Yes or No If yes, name of church__________________________________

Please give any special instructions which you feel may help the Preschool Staff work well with your child. Please use the back of this page if needed!!