



New Beginnings Preschool at Grace Lutheran Church

925 Fifth Avenue, River Edge, NJ 07661 Tel: 201-261-5415/Fax: 201-483-9360

E-Mail: admin@newbeginningsatgrace.com

REGISTRATION FORM

GENERAL CONTACT

Child Name: _____ Date of Birth _____ Sex: M__F__

Home Address: _____

City/State/Zip _____

Best Daytime Phone # _____ Primary E-Mail: _____

CLASS SCHEDULE

Choose the class schedule that meets your needs: half-day, full-day, or a combination. **A minimum of two days per week is required in the 2-year-old room. A minimum of three days per week is required in the 3 and 4-year-old rooms. Kindergarten is 5 full days only.**

Class	Days of the Week (check days required)				
	Monday	Tuesday	Wednesday	Thursday	Friday
Half-Day 8:30 AM-12:30 PM					
Full-Day 8:30 AM-3:30 PM					

Extended hours of childcare \$6.00/Hour (DROP-INS \$10.00/Hour)

ONE HOUR MINIMUM WITH HALF HOUR INCREMENTS THEREAFTER

Write TIMES on each day needed for Before and/or After Care					
	Monday	Tuesday	Wednesday	Thursday	Friday
BeforeCare 7:00AM-8:30AM					
AfterCare 3:30PM-7:00PM					

FAMILY INFORMATION

	Parent/Guardian 1	Parent/Guardian 2
Name		
Cell Phone		
E-Mail		
Occupation		
Company Name		
Company Address		
Work Phone		



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Child Name: _____ Date of Birth: _____ Sex: M ___ F ___

Please list all members of household and ages of children

Marital Status: Married _____ Divorced _____ Separated _____

If parents are not living together, with which parent does child reside? _____

Please give specific instructions regarding custody and visitation arrangements if parents are not living together. *If there is a visitation court order in effect, please provide a copy to the school office.*

EMERGENCY CONTACT INFORMATION

Please provide information on **two** individuals **in addition to parents/guardians** that we may contact in the event of an emergency and we cannot reach you.

	Emergency Contact 1	Emergency Contact 2
Name		
Address/City		
Best Daytime Phone		
Relation to Family		
Authorized Pick Up?		

Please list any other individuals authorized to pick up your child from school.

AUTHORIZED CHILD PICK UP

Name	Phone	Address	Relation to Family

(parent signature)

(date)



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MEDICAL INFORMATION AND RELEASE

Please provide a copy of your child's most recent immunization and health records stamped or signed by your pediatrician – these are required in order for your child to begin school.

Child's Allergies (list any known)	
Child's Medications (list any currently in use)	
Pediatrician	Name:
	Address:
	Telephone:
Medical Insurance	Provider:
	Policy ID:
	Policy Holder Name:
Hospital Preference	

As parent/guardian, I give consent to have my child, _____, receive first aid by the childcare staff, *and if necessary*, be transported to the hospital to receive emergency care. I give consent for the emergency contact person listed below to act on my behalf until I am available. I understand that I will be responsible for all charges not covered by insurance. I agree to review and update this information whenever a change occurs.

Parent/Guardian Signature _____ Date _____

EMERGENCY CONTACT OTHER THAN PARENT/GUARDIAN

In the event you are unable to reach me or my spouse, please attempt to contact the following person, whom I give authorization to give consent for medical care for my child:

Name: _____ Relationship: _____

Best Contact Phone: _____

Address/City: _____



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Child Name: _____ Date of Birth: _____ Sex: M__F__

Will your child be in diapers/pull-ups when he/she starts school? Y____N____

(Please provide a supply of diapers/pull-ups and wipes for your child)

****Please note** Students enrolling in the 4-year-old class NEED to be fully potty trained before enrollment.**

Does your child receive any special educational services? Y____N____

If yes, please provide below any information that will be helpful, so we can explore providing or supplementing services your child might need. Please include any evaluations and documents of development that would assist in supporting your child's educational needs.

I give permission for my child or my family to participate in the following activities:

Check Yes or No

*YES, I give
permission*

*NO, I do not give
permission*

Voice/Photo/Video

Permission to use child's voice, photograph (without name) or video to promote New Beginnings Preschool with the public (e.g., advertising, news items for local newspaper, church bulletin or newsletter)

Reference for Prospective Parents

Permission to use name as reference for parents interested in the preschool, who may contact you with questions.

I understand that there will not be any refund for missed scheduled days. This is a preschool/kindergarten and the monthly tuition insures my child a spot at the school. If my child is out due to illness or vacation, standard tuition is charged and will not be discounted, prorated or refunded.

If I choose to terminate enrollment at any time before or during the school year, I understand that I forfeit the security deposit and the tuition of the current month.

Signature: _____ Date: _____