



2415 Silas Creek Parkway
 Winston-Salem, NC 27103
 (336) 725-1651 • Fax (336) 725-1603
 www.StJohnsFalcons.org



Application Date _____

Date of Enrollment _____

Application for Enrollment 2015-2016 Preschool/Pre-Kindergarten

Child's Name _____ Date of Birth ____/____/____

Street Address _____ City, State, Zip _____

Male/Female ____ Race/Ethnic Group: _____ Is child adopted? ____ Home Phone _____

Father's Name _____ Mother's Name _____

Employer _____ Employer _____

Work Phone # _____ Work Phone # _____

Cell Phone # _____ Cell Phone # _____

Email _____ Email _____

Church Membership _____ Church Membership _____

Parents' Marital Status: ____ Married ____ Widowed ____ Single ____ Separated ____ Single
 ____ Divorced ____ Remarried

Child lives with: ____ Both Parents ____ Mother ____ Father ____ Other

My child will be enrolling for (check one):

Preschool 3's: ____ Half Day (TWR 8:00-noon) ____ Half Day (M-F 8:00-noon)
 ____ School Day (8:00-3:00) ____ Full Day (7:30-6:00)

Pre-k 4's Readiness: ____ Half Day (M-F 8:00-noon) ____ School Day (M-F 8:00-3:00)
 ____ Full Day (M-F 7:30-6:00)

If child is enrolling in Half Day program, will child occasionally stay for nap? ____ Yes ____ No

List any fears, unique behaviors, etc. your child may have:

What discipline methods do you use at home that would be helpful for us to know (e.g. time out, rewards, certain phrases or words, etc.)

Name of person who will be financially responsible to pay all fees and tuition charges. _____

I have received and read a copy of the state of North Carolina Child Care Laws: ____ Yes ____ No



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Emergency Care and Desired Action Information

Does the child have any known allergies? ___ Yes ___ No If yes, please explain _____

Does the child have physical handicaps? ___ Yes ___ No If yes, please explain _____

List any maintenance medications: _____

Preferred Hospital _____

In case of serious injury/accident or accident requiring immediate medical attention, student will be taken to nearest hospital.

Health Insurance Carrier _____

Policy # _____ Group # _____

Name of Child's Physician _____ Office Phone # (____) _____

If neither parent is reachable, whom may we release your child to in case of illness or emergency or we cannot reach you? (For your child's protection photo ID is required): When a parent is called because the child has become sick at school, the child must be picked up within an hour. Also the child cannot return the next day and/or after fever has broken for 24 hours.

Name _____

Relationship _____ Home # _____ Work # _____ Cell # _____

Name _____

Relationship _____ Home # _____ Work # _____ Cell # _____

Name _____

Relationship _____ Home # _____ Work # _____ Cell # _____

I give permission to St. John's Lutheran Preschool/School and its staff to administer First Aid and/or CPR if needed. I understand that all preschool staff members are First Aid and CPR certified. I also give permission to St. John's Lutheran Preschool/School and its staff to obtain medical treatment in the event of an emergency. I agree that St. John's Preschool/School may authorize the physician of their choice to provide emergency care in the event neither parents nor the child's physician can be contacted immediately. I understand that we, the legal guardians, will be contacted immediately in the event of an emergency.

I have read and discussed application/practices and policies/procedures with the Preschool Director. I accept the practices and policies of St. John's Lutheran Preschool and School. I will abide by the educational and financial policies herein set forth and by the regulations and administration

Parent/Guardian signature: _____ Date _____