

**2 1/2 -year -old Enrollment Form
2010-2011**

**Holy Trinity Preschool
6322 S Lakeview
Littleton, Colorado 80120
Director: Tracy Seul, (303) 797-6345
FAX: 303-798-1356**

Date of Enrollment: _____

Payment:

Check # _____

Cash _____

For Office Use only

To enter a 2 1/2 year-old class in the fall of 2010-2011 the child must turn two on or before 4/01/10.

TTh 9-1: _____ **MWF 9-1:** _____ **MTWThF 9-1:** _____

Tuition Rates: T/Th - \$ 225.00 MWF- \$ 315.00 MTWThF: \$ 540.00

Registration Fee: (Due at the time of enrollment; this is what secures a child's spot; it is non-refundable.)

Returning Family: \$ 60.00 per child New Family: \$ 80.00 per child

Child's Date of Birth: _____

Child's Name _____

Boy/Girl

Home Address (include city and zip code) _____

Primary E-mail: _____

Home Telephone: _____

Father or Guardian's Name _____

Address (if different from child's)

Cell Phone: _____ Pager: _____

Employed: _____ Work Phone: _____

Mother or Guardian's Name _____

Address (if different from child's)

Cell Phone: _____ Pager: _____

Employed: _____ Work Phone: _____

Emergency Contact (if parents cannot be reached):

Name: _____ Relationship to child: _____

Address: _____

Phone: _____ Cell Phone: _____

Please finish completing this form on the back.

Child's Doctor: _____ Telephone: _____

Address _____ City _____ Zip _____
Child's Dentist: _____ Telephone: _____

Address _____ City _____ Zip _____

Describe health concerns or handicapping conditions that your child has: _____

List any instructions or limitations for the medical or handicapping condition: _____

Check illnesses the child has had:

___ Measles ___ German Measles ___ Chickenpox ___ Mumps
___ Strep Throat ___ Rheumatic Fever

Has this child had contact with tuberculosis? Yes No

Home Church: _____

I would like my name, address and phone # listed in the Preschool Directory: Yes No

Statement of Medical Authorization

I, _____, hereby give my permission to Holy Trinity Preschool to seek medical or surgical care for my child, _____, should an emergency arise. It is understood that a conscientious effort will be made to contact the parent(s)/guardian before any action is taken. However, if we are unable to be reached, we will accept responsibility for any expense.

Signature of Parent or Guardian

Medical Insurance: _____ **Date:** _____

Hospital Preference: _____ **Phone:** _____

Address

Please List other family members living in your household (excluding child and parents):

Name: _____ Age: _____ Relation: _____

Name: _____ Age: _____ Relation: _____

Name: _____ Age: _____ Relation: _____

Name: _____ Age: _____ Relation: _____