Trinity Episcopal Preschool
533 Second Street
Natchitoches, LA 71457
Telephone: (318) 352-3113

Date Received:______

Please circle one: Part Time or Full Time

REGISTRATION FORM

The undersigned parent(s), custodian(s), and/or legal guardian(s) hereby register their child, __________________________, for the school year of ___________ in Trinity Episcopal Preschool (TEP) for the (check one) 3 yr___, 4 yr___, or TK___ class.

If accepted, I/We agree to pay tuition for the school year. Tuition is payable in advance by total sum or monthly. Annual tuition for the full day program is $4500.00 or $450.00/ month. Annual tuition for the half day program is $2000.00 or $200.00/month. There is also a non-refundable fee of $200.00 due when your child has been accepted into the program. In case of illness lasting more than six weeks duration or removal from the city, a tuition adjustment will be made. If a child is withdrawn for any other reason, a one-month notice or tuition will be required.

Trinity Episcopal Preschool reserves the right to request a child's withdrawal if he/she requires special attention not provided in the program, or demands excessive supervision that the class is unfavorably affected.

Child's Name: ______________________ M / F DOB: ___ / ___ / _____

Child's Lives With:_______________________ Left / Right Handed

Family Information	**Mother/_______________**	**Father/_________________**
Name		
Address		
Employer		
Home Phone		
Work Phone		
Cell Phone		
Email Address		

Submit **this page only** to register your child. If your child is accepted into the program, TEP will contact you and ask for the $200 supply fee to hold the spot. The rest of the registration packet will be required at that time. We keep this registration form only for the year requested. If you child does not get in and you would like to put them on the waiting list for the next year, please let us know!

Individuals to Contact in Case of Emergency **Phone**

1. ____ ____________________
2. ____ ____________________
3. ____ ____________________

Child can be released to the following individuals. **Relationship**

1. ____ ____________________
2. ____ ____________________
3. ____ ____________________

Child's Physician: __________________________ Phone: __________________

Child's Dentist: __________________________ Phone: __________________

Allergies: ____

Medical condition or disability that would require special attention or help. No / Yes

If Yes, please specify. ____

Children attending TEP should be daytime potty-trained. At what age was your child completely daytime potty-trained? ______________________________________

I am enrolling my child for: ____________ Half Day Program.

____________ Full Day Program.

I authorize this facility to:

1. care for my child during the time he/she is in TEP;
2. secure emergency medical care for my child in the event parents or others listed for emergency contact cannot be reached. I understand every effort will be made to contact parents/custodians/guardians or others listed.

____ ____________________

Signature of Parent/Custodian/Legal Guardian Date

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PARENT-CHILD QUESTIONNAIRE

Please help us get to know your child by completing and returning this questionnaire. All of this information will be kept in your child's portfolio and used only for planning purposes. Thank you for your assistance.

Child's Name: ____
First Middle Last

Nickname: ____

Date of Birth: ____ / ____ / ______ Place of Birth: ____________________

Child lives with: _____ both parents _____ one parent _____ other adults

(please specify) ____

Names and ages of any brothers ____________________________

Names and ages of any sisters ____________________________

Pets (Name and Type of animal) ____________________________

Describe your child's strong dislikes or fears ____________________

____

What are your child's favorite play activities and interests? ______________

____

Does your child usually play (check all that apply): _____ alone? _____ with one friend?

_____ with many children? _____ with a few children ? _____ with older children?

_____ with younger children? _____ with children of the same age?

What type of childcare did your child receive before enrolling in this program?

_____ none (home with parent) _____ daycare _____ babysitter/nanny at home

_____ relative's home _____ in a babysitter's home _____ other ______________
please specify

Does your child have a regular bedtime? _____ yes _____ no

Does your child nap during the day? _____ yes _____ no _____ sometimes

What are your child's responsibilities at home? ______________________________

____

What activities does your family enjoy doing together? ______________________________

____

Please list any nervous habits your child may have? ______________________________

____

How does your child feel about going to school? ______________________________

How do you think your child will adjust to school? ______________________________

____

What do you hope your child will learn this year? ______________________________

____

Please add any additional information or comments you feel will help us in planning and caring for your child?

____

____

____

____

____

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CONSENT FOR EMERGENCY MEDICAL TREATMENT

I/We, the undersigned parent(s), custodian(s), and/or legal guardian(s) of

______________________________ DOB: ___ / ___ / _____

do hereby expressly give permission to the staff of Trinity Episcopal Preschool to request emergency medical treatment to the above named child(ren) for the period of

___ / ___ / _____ to ___ / ___ / _____
Starting Date Ending Date

During this time period, I do hereby expressly grant permission to the above named minor(s) listed above to consent to any and all emergency or necessary medical treatment which may be unexpectedly required; this consent for medical treatment is to be valid according to the laws of the state of Louisiana. I/We also ask to be immediately notified or that repeated attempts be made to notify me/us at the telephone numbers listed below should any medical treatment be required.

______________________________ ______________
Signature of Parent/Custodian/Legal Guardian Date

______________________________ ______________
Signature of Parent/Custodian/Legal Guardian Date

LOUISIANA IMMUNIZATION REQUIREMENTS FOR STUDENTS IN ACCORDANCE TO R.S. 17:170

STUDENT IMMUNIZATIONS – SCOPE OF REQUIREMENTS

Middle School Requirement:

Beginning with the 2009-2010 school year and continuing thereafter, a student shall provide satisfactory evidence of current immunizations against meningococcal disease, and any other age appropriate vaccines, as a condition of entry into the sixth grade. Further, any student who has attained the age of eleven years or who is entering grade other than grade six shall provide satisfactory evidence of current immunizations against meningococcal disease and any other age appropriate vaccines as a condition of entry into that grade.

At the time of registration, students must show proof of immunization of the following vaccines: Tetanus Diphtheria Acellular Pertussis vaccine (TdaP); two (2) doses of Varicella vaccine; two (2) Measles, Mumps, Rubella (MMR) vaccines; three (3) Hepatitis B (HBV) vaccines; and one (1) Meningococcal Vaccine (MCV4).

Kindergarten / First Time Enterers:

Beginning in school year 2009-2010, two (2) doses of Varicella vaccine shall be required in Louisiana schools for entry into kindergarten or first time enterers into school. In addition, prior to school entry, these students must have documented proof of immunizations for: two (2) doses of Measles, Mumps, Rubella (MMR) vaccine; three (3) doses of Hepatitis B (HBV) vaccine; and booster doses of Diphtheria Tetanus Acellular Pertussis (DTaP) and Poliovirus (Polio) vaccines administered on or after their 4th birthday *and* prior to school entry. If a student is not complete (up-to-date for age), he/she must present a record indicating the student is in progress of receiving vaccines, and follow-up must be provided for compliance with the above requirements.

Pre-Kindergarten / Daycare / HeadStart:

Beginning school year 2009-2010, two (2) doses of Varicella vaccine will be required in Louisiana schools for entry into Pre-K, Kindergarten, Daycare, and HeadStart programs for children aged 4 years and older. If a second dose of Varicella vaccine has been received at least 30 days after the first dose, no additional doses are required. This is in addition to the regular age appropriate vaccines required depending on the child's age. Prior to entry, these students must have documented proof of immunizations for: two (2) doses of Measles-Mumps-Rubella vaccine; three (3) doses of Hepatitis B vaccine; and booster doses of DTaP and Polio vaccines administered on or after their 4th birthday and prior to school entry.

All children aged less than 4 years of age enrolled in Pre-K, Daycare, HeadStart, etc should be vaccinated against and must show proof of immunizations for: Diphtheria Tetanus Acellular Pertussis vaccine (DTaP); Inactivated Poliovirus vaccine (IPV); Haemophilus Influenza Type B vaccine (Hib); Hepatitis B vaccine (HBV); Pneumococcal Conjugate Vaccine (PCV7 – for children less than 24 months of age); and one (1) dose of Varicella vaccine. If the child is not complete or up-to-date for age, he/she must present a record indicating that the child is in progress of receiving vaccines, and follow-up must be provided for compliance with the above requirements

SCHEDULE D

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS (ACH DEBITS)

I (we) hereby authorize TEP, hereinafter called COMPANY, to initiate debit entries to my (our) Checking account indicated below and the depository named below, hereinafter called DEPOSITORY, to debit the same to such account.

☐ Checking Account ☐ Savings Account

DEPOSITORY NAME ______________________________

ROUTING NUMBER ______________________________

ACCOUNT NO ______________________________

AMOUNT OF DEBIT(S) ______________________________

DATE(S) AND/OR FREQUENCY OF DEBIT(S) ______________________________

This authority is to remain in full force and effect until COMPANY and DEPOSITORY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

CONSUMER NAME (S) ______________________________

(PLEASE PRINT)

DATE ______________

SIGNED ______________________________

SIGNED ______________________________

VISION SCREENING CONSENT/Result FORM

On ________________, the local Lions Clubs in your community will offer a free vision screening to your child. Utilizing instant photographs and/or an auto-refraction of your child's eyes, the screening may determine the presence of eye disorders including far and nearsightedness, astigmatism, strabismus (crossed or misaligned eyes), anisometropia (unequal refractive power), and media opacities (i.e. cataracts). No physical contact is made with your child and eye drops are not necessary. ***For more information on the Cubsight Program, please call Toll Free 1-866-282-7483 or visit: www.cubsight.org***

I, the undersigned, hereby give permission for my child,____________________________, to participate in the screening event. I understand the following regarding this program:

1. **The information obtained from this vision screening is preliminary only, and does not constitute a complete exam or diagnosis of vision problems.**
2. **There is no charge to participate in the vision screening process.**
3. **I will be contacted either by telephone or in writing with the results of the screening through the Louisiana Lions Cubsight Program.**
4. **I understand that I am responsible for arranging for a complete eye exam if my child has been referred as a result of the screening test.**
5. **If referred, I authorize the examiner to release the results of my child's exam to the Cubsight Program and/or my child's school/day care facility.**
6. **I will not hold the Lions Club organizations, the Louisiana Cubsight Program, or the Louisiana Lions Eye Foundation accountable for any errors of commission, omission or other misdiagnosis.**

X______________________________________ ______________________
Signature of Parent or Guardian DATE

Please Print or Type

Child's Name:____
First Middle Last

Child's Date of Birth:__________________ Child's Age: __________

Address:____

City and zip: _______________________________________

Phone: ( ) ____________________ / ( ) ____________________
Home Work / 2nd Number

VOLUNTEER:
ATTACH CHILD'S WELCH ALLYN PRINTOUT(s) HERE

WRITE CHILD'S INITIALS BY "NAME" AND DATE OF BIRTH BY "DATE" ON THE PRINTOUT

Wearing Glasses? _______Yes ________No

The Results of Your Child's vision screening is as follows:

______**PASS** The screening was unable to detect a problem at this time. Please realize this test is not a substitute for a complete pediatric eye exam. Consult your pediatrician if you suspect a vision problem.

_____ **BORDERLINE** Your child may have a mild refractive error (need for glasses) that may not need to be evaluated formally at this time. We recommend the child be re-screened by his/her eye doctor in one year.

_____**UNREADABLE SCREENING: No reading** ☐Right Eye ☐ Left Eye **ADULT SETTING** ☐
(Lions will rescreen) **Reliability # < 6** ☐Right Eye ☐ Left Eye

_____**REFER** Schedule exam for your child as the screening suggests they may have the following condition(s) that may cause poor vision in one or both eyes. Please take your child to an Opthalmologist or Optometrist in your area (see attached) for a complete exam:

☐ Astigmatism ☐ High Farsightedness ☐ High Myopia (nearsighted)
☐ Anisometropia (difference in need for glasses between two eyes) ☐ Other

LLCP(07-14)