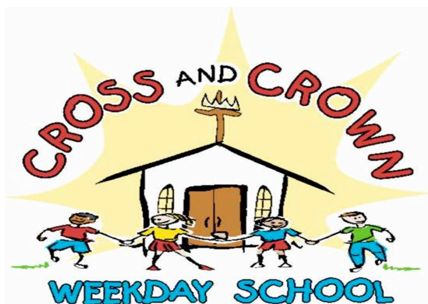
Office Use Only: Date Rec'd___________Notified_________Fee Pd___________Check #_____________



ENROLLMENT FORM 2012-2013

300 Pineville-Matthews Rd.
Matthews, NC 28105
704-844-8997
cncwds@windstream.net

REGISTRATION FEE*: $100 PER CHILD OR $150.00 PER FAMILY

Please check the correct box.

2 year old	3 year old	4 year old
☐ 2 Days (Tues-Thurs)	☐ 3 Days (Tues-Wed-Thurs)	☐ 3 Days (Tues-Wed-Thurs)
☐ 3 Days (Mon-Wed-Fri)	☐ 4 Days (Mon-Thurs)	☐ 4 Days (Mon-Thurs)
☐ 5 Days (Mon-Fri)	☐ 5 Days (Mon-Fri)	☐ 5 Days (Mon-Fri)

☐ TK - Transitional Kindergarten - (5 days per week only)

Monthly Tuition Fee $____________

Child's Last Name_______________________First______________________Middle______________

Preferred Name: ______________________________ Birth Date: _____/_____/______Sex: _______

Address:______________________________________ City:__________________ Zip:__________

Mother/Guardian's Name:___________________________ Occupation:_________________________

Address (if different):______________________________ City:___________________Zip:________

Cell_______________ Home ______________ Wk ________________Email___________________

Father/Guardian's Name:____________________________ Occupation:________________________

Address (if different):______________________________ City:___________________Zip:________

Cell______________ Home ______________ Wk ________________Email____________________

Names and Ages of Other Children at Home:____

PRESCHOOL EXPERIENCE

Has your child had previous preschool experience? Yes _____ No _____ How long? ___________

PLEASE FILL OUT MEDICAL AND EMERGENCY INFORMATION ON BACK

*Registration fee is non-refundable

PICK UP AUTHORIZATION

Any exceptions to the following list *must* be received from the parents in written form.

Name: ____ Relationship to child:_________________

Cell:____________________ Home: ____________________ Work: _______________________

Call in case of emergency?: Yes ______ No _______

Name: ____ Relationship to child:_________________

Cell:____________________ Home: ____________________ Work: _______________________

Call in case of emergency?: Yes ______ No _______

Name: ____ Relationship to child:_________________

Cell:____________________ Home: ____________________ Work: _______________________

Call in case of emergency?: Yes ______ No _______

PHOTO RELEASE

I give permission for Cross & Crown Lutheran Church and the Weekday School to use photos taken of my child in publications for the school (graduation videos, directories, website, brochures, etc.).

Parent/Guardian Signature:_____________________________________ Date:_______________

MEDICAL INFORMATION

DOCTOR:_______________________________ PHONE:_____________________________

INSURANCE COMPANY:_________________________ POLICY #:_____________________

KNOWN ALLERGIES: YES ______ NO ______

If yes, please list:____

Does your child have any other special needs that we should be aware of? Yes _____ No ______

If yes, please explain:__________________________________-______________________

Medical Authorization

I understand that, in the event medical treatment is required, every effort will be made to contact us. However, if we cannot be reached, we give permission to the staff of Cross & Crown Weekday School to secure whatever medical services are needed for our child's well being.

Signature (Parent/Guardian):________________________________ Date:________________

Please provide a copy of your child's immunization records with this form.