



New Beginnings Preschool
at New Hope Worship Center

Please complete and return, along with the registration fee to secure your child's space.

Name of Child: _____ Age(as of Aug. 31st) _____

Parent or Guardian: _____

Phone: _____ Cell: _____

Address: _____

Please select the days you would like your child to attend preschool

<u>Age</u>	<u>Class Options</u>					
2 yrs old	TuTh					(9:00-12:00)
3 yrs old	M-F	M-Th	MWF	TWTh		(9:00-12:00)
4yrs old	M-F	M-Th	MWF	TWTh		(9:00-12:00)

<u>Monthly Tuition Rates</u>	<u>Yearly Enrollment Fee</u>
2 days \$175*	
3 days \$205	\$200 for all classes
4 days \$255	
5 days \$305	

*The two day option is only available for two year olds.

Tuition is payable on the first of each month. Enrollment fees cover the cost of insurance, curriculum and additional supplies.

Signature (Parent or Guardian): _____

Registration Information

Child's Complete Name: _____

Name Called: _____ Sex: _____ DOB: _____

Address: _____

Mother's Name: _____ Phone: _____ Cell: _____

Occupation: _____ Business Phone: _____

Email Address: _____

Father's Name: _____ Phone: _____ Cell: _____

Occupation: _____ Business Phone: _____

Email Address: _____

Others authorized to pick up child from preschool: _____

_____ Phone: _____

Emergency Contact: _____ Phone: _____

Siblings: _____ Age: _____

_____ Age: _____

Family Pets: _____

Church Preference: _____

Child has a tendency to be: Right handed: _____ Left handed: _____

Child is frightened or upset by: _____

Child is comforted by: _____

Child's favorite things: _____

With whom does child usually play? _____

How does he/she get along with playmates or siblings? _____

How does he/she show feelings? _____

What method of discipline is used when he/she behaves in a way that is not acceptable? _____

Is child toilet trained? _____ (must be trained before entering 3 yr class)

What goals or expectations do you have for your child's preschool experience?

Medical Allergies: _____ Regular Medications: _____

Medical conditions we should be aware of: _____

Physician: _____ Phone: _____

Signature of parent or guardian: _____