

OFFICE USE

Class _____

Registration Fee _____

**TRINITY LUTHERAN PRESCHOOL
119 Texas Street
Bellingham, WA 98225
(360) 734-2770
Registration Form**

Child's Name: _____
(Last) (First) (Nickname)

Address: _____ Phone: _____
(Street or PO Box)

_____ Sex: _____

Birthdate: _____

Church You Attend: _____ Baptismal Date: _____

Father's Name: _____

Place of Employment: _____ Work Phone: _____

Mother's Name: _____

Place of Employment: _____ Work Phone: _____

Email address: _____

Please list brothers and sisters names and ages:

(Name) (age) (Name) (age)

(Name) (age) (Name) (age)

Class Preference (Please check one)

_____ Monday, Wednesday, Friday

_____ Tuesday, Thursday

List All The People Who Will Be Bringing Or Picking Up Your Child

Name of Anyone **Not** Permitted To Pick Up Your Child

Please list any circumstances relevant to your child's emotional status (new baby, separation, divorce) that you would like us to know about.

Social History

List child's previous group experiences:

Activities your child enjoys:

Child's fears and anxieties and how exhibited:

What concerns do you have about your child that the teacher should know about:

Physical History

Allergies: Food _____
 Medicine _____
 Other _____

Other medical information we should be aware of:

Child's Name _____

I understand that no emergency treatment may be given without parental consent except in a life-threatening situation. Because informed consent must be given at the time of the incident, I agree to leave numbers where I (or my spouse or responsible adult designated by me) can be reached promptly if the numbers below do not apply for any day.

In case of a medical emergency while my child is attending Trinity Lutheran Preschool I understand that the following procedure will be followed:

1. The program will contact the parents:

Mother can be reached at _____ during _____
(phone #) (hours/days)

Father can be reached at _____ during _____
(phone #) (hours/days)

2. If neither parent is available in an emergency the program will contact the following people:

Name _____ can be reached at _____
Relationship to child _____

Name _____ can be reached at _____
Relationship to child _____

3. The program will arrange for emergency transportation to the nearest medical facility. My child will be transported by an ambulance or other such vehicle when necessary.
4. The program may contact my child's medical provider in the event of an emergency when none of the above adults can be reached.

Physician's name _____ Phone _____

I hereby authorize the program to follow the above outlined procedures.

Parent signature _____ Date _____