ALL SAINTS' UMC PRESCHOOL

2025 - 2026 Registration Form

Program Days & Hours Monday – Thursday 9:15 am – 12:15 pm
Serving children ages 22 months through 4 years

REGISTERING FOR: *please indicate the class and days*

☐ **2's Class** Caterpillar Classroom (child must be 22 months old by 10/31/25)
- ☐ 2 Days $225/month **Circle Days Prefered**: M/T or W/Th
- ☐ 3 Days $310/month (T-Th)
- ☐ 4 Days $375/month (M-Th)

☐ **3's Class** Butterfly Classroom (child must be 3 years old by 10/31/25)
- ☐ 3 Days $300/month (T-Th)
- ☐ 4 Days $350/month (M-Th)

☐ **4's Class** Caterpillar Classroom (child must be 4 years old by 10/31/25)
- ☐ 3 Days $300/month (T-Th)
- ☐ 4 Days $350/month (M-Th)

** A **non-refundable Registration Fee equal to 1 month's tuition** is required with this form. Checks should be made out to **All Saints' UMC Preschool**. **EFT payments** can be made online - see the included **Payment Options** document for instructions.*

Full Name of Child:_____

Name Child Goes By: _____ Sex: M / F

Date of Birth: _____ Age on 10/31/2025: _____

Home Address: _____

City: _____ State:_____ Zip: _____ County: _____

Home Phone: _____

Brothers/Sisters (names) and Ages: _____

_____

Previous Preschools/Daycares Attended:_____

_____

Mother/Guardian's Name: _____

Address if different from child's: _____

Cell Phone: _____ Email: _____

Father/Guardian's Name:_____

Address if different from child's: _____

Cell Phone: _____ Email: _____

Please list persons who are authorized to pick your child:

_____

_____

_____

Please list persons to be contacted in case of emergency if neither parent/guardian is available. *(preferably individuals that are no more than 15 minutes away from the program)*

Name: _____

Relationship: _____ Cell Phone: _____

Name: _____

Relationship: _____ Cell Phone: _____

Medical Information: (will remain confidential)

Name of Child's Doctor: _____

Doctor's Address: _____

Phone Number: _____

Insurance Carrier: _____

Policy Holder: _____ Policy #: _____

Are your child's immunizations up to date? _____

** A current immunization record will be required **BEFORE** your child's first day of school. **

Child's known allergies (medicines, foods, bee stings, etc.), dietary restrictions or preferences, or other health concerns: _____

_____

_____

_____

_____

_____

Any other information we should be aware of to help us better care for your child (developmental concerns, IEP, past or current therapy services, separation anxiety, etc.):

_____

_____

_____

_____

_____

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_____

_____

_____

In the event deemed necessary by the staff, I authorize All Saints' Preschool to seek medical attention for my child, with or without contacting me. I further understand that I will be responsible for any and all medical expenses incurred, and will indemnify and defend All Saints' Preschool against any and all claims related to such expenses or otherwise related medical care.

Date: _____ Signature: _____