Covenant Community Preschool an outreach mission of First ARP Gastonia

2011-2012

ENROLLMENT APPLICATION

CHILD'S NAME: _____
Last First Preferred name child is called

PARENT(S): _____
Last father's first name mother's first name □married, □divorced, □separated, □widow

Legal custody, Joint? YES NO Legal custody, Mother? YES NO Legal custody, Father ? YES NO

Address_____
Sub-Division Street City State ZIP

Home phone _____ Father's Cell #_____ Mother's Cell #_____

Father's Employer _____
Name Address Phone #

Mother's Employer _____
Name Address Phone #

First ARP Church, Gastonia: Member Non Member Religious Affiliation/ Beliefs _____

Sex: M F Birth Date ____/____/_____ Doctor: _____
Name Phone

Allergies/ Health concerns: _____

A physician's individualized care plan is required **before** beginning school for children with special health care needs, food allergies or special nutrition needs.

Additional information which may be useful. (Fears, interests, personality, etc.)_____

Emergency contact 1: _____
(Cannot be a parent, 2 names required) Name Phone Relationship to child

Emergency contact 2: _____
Name Phone Relationship to child

Number of siblings ____ ages: _____ Previous Preschool experience: YES NO If yes, where? _____

How did you learn of Covenant Community School? _____

Please circle the age appropriate program desired and mark your first and second choice of programs-

Program	2 day	3 day	5 day		
4 year olds			Mon. / Fri. PRE-K		
3 year olds	Mon/Tues	Wed / Fri			
2 year olds	Mon. / Tues.	Wed. /Fri.			

It is understood and agreed that First ARP of Gastonia and staff are hereby released from all claims or financial responsibility arising out of any accident or mishap that may occur in connection with the operation of the school or from illness that may be contracted by the child during the period of enrollment.

* If the parent/ legal guardian is unable to be reached in an emergency, the school has our permission to obtain medical attention for our child,

_____ (child's full name) from _____(physician's name and phone #),

or Gaston Memorial Hospital Emergency Room. If ER is deemed necessary, child will be transported by Gaston Emergency Medical Services.
Name of Primary Insurance Policy_____ Policy # _____

Please attach a copy of current insurance card.

_____/_____/_____ _____
Date Parent / Legal Guardian Signature Signature certifies all the above information is true to the best of my knowledge