

2017-2018
Buford First UMC Preschool
285 E Main St. Buford, GA 30518
Mailing: P.O. Box 329 Buford, GA 30515
770-945-4161
Preschool@BufordFirstumc.org
Three-Year Old Program

Child's Name _____ Birthday ____/____/____
 (Please underline name preferred)

Mailing Address _____
 (Street, city and zip so that we may contact you during the summer)

City _____ Zip _____ Home Phone _____

Please note the following:
Your child must be 3 years old by September 1, 2017 and toilet trained
Hours: 9:00am-1:00pm
Class Schedule:

Three Days:	Four Days:
Tuesday-Thursday	Monday-Thursday
Mo. Tuition: \$175.00	\$195.00
Activity Fee: \$90	\$100

Please Attach Non Refundable Registration Fee with application
Reg Fee: \$175.00 \$195.00
Activity Fee and September tuition is due August 30, 2017 at Open House

Is this your child's first child care experience? If No, please state place and length of time.

Facility _____ Length of time _____

Mom's Name _____ Occupation _____

Work # _____ Cell # _____

Dad's Name _____ Occupation _____

Work # _____ Cell # _____

Marital Status: Single Married Separated Divorced

Church Preference: _____

OFFICE USE ONLY: Registration Fee ____/____/____
 Acceptance Letter Sent _____
 Summer Letter Sent _____
 September Tuition _____
 Activity Fee _____
 Immunization Record _____
 New Student _____ Teacher _____



Waiver of Liability:
Should my child become ill or injured during the time he or she is in the care of Buford First UMC Preschool and PMO, I understand the school's policy is as follows:

1. The school shall undertake contacting me
2. In the event the school is unable to contact me, the school shall attempt to contact the following persons listed below.
3. Should this fail, the school shall be authorized to secure such medical attention and care for my child as deemed necessary.

Signed _____ Date _____

Names and phone Numbers of Persons to contact me in case of emergency

Name _____ Phone _____

Relationship _____

Name _____ Phone _____

Relationship _____

Name _____ Phone _____

Relationship _____

Child's Pediatrician _____ Phone _____

Other _____ Phone _____

Name (s) of all persons authorized to pick up your child from school parents will be assumed unless noted. Changes to this list must be submitted in writing before the child can be released to a new person.

Name _____ Phone _____

Name _____ Phone _____

It is the responsibility of the parent to inform us of any custody issues that might concern the preschool.

Siblings (Names and ages):

Email address: _____

Does your child have physical handicaps, speech problems, and emotional problems?

_____ Yes _____ No Does your child have allergies? _____ Yes _____ NO

If yes, please explain. If your child has allergies, please explain his/her reaction.

We strive to meet the needs of each individual child, but if we feel we are not qualified to handle your child's special needs, we reserve the right to refuse the application and return the registration fee.



Child's Name _____ Days Attending _____ Teacher _____

Family Information

Please help us plan for your child's need, understand concerns, and support and encourage your child by providing the following information. The information will remain Confidential and we hope you will update it as necessary.

Others in your household other than parents and siblings: please provide ages and relationships:

Other significant persons in your child's life: (step families, grandparents, baby-sitters, etc.)

Does your child have a pet? Type of pet: _____ Name of pet: _____

Have there been births, deaths, adoptions, or other changes in the family structure that affected your child? If so, describe briefly what happened, the effect on your child, and tell us how you explained this event to your child.

What opportunities does your child have to play with other children?

_____ Neighborhood _____ Sunday School/Church _____ Relatives
_____ Nursery school or other classroom experience _____ other _____

What are your child's favorite play activities?

Do you consider your child easy or hard to manage?

What methods of discipline have you found most effective?

What fears does your child have and how are they expressed?

What do you and your child enjoy doing together?

What trips, vacations, or other family experiences are remembered with the most pleasure?

What special happening is your child apt to tell us about?

How much television does your child watch each day? _____ What are his/her favorite programs?

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How much sleep does your child require daily?

Does your child nap regularly? Yes/No Nap time: _____ Usual bedtime: _____

What communicable diseases has your child had? Indicate age:

_____ Chicken Pox _____ Scarlet Fever _____ Mumps _____ Measles
_____ Impetigo _____ Conjunctivitis (pink eye)

Does your child have frequent?

_____ Colds _____ Coughs _____ Ear Infections _____ Tonsillitis _____ High Fever
_____ Upset stomach _____ Convulsions _____ Seizures

Has your child had serious illness, surgery, or a hospital stay? If so, please describe condition and child's reaction.

Does your child have any abnormality of _____ Skin _____ Glands _____ Extremities?

_____ Genitalia _____ Nervous System If so, please describe.

Is child in diapers? _____ or are bowel and bladder functions regular and under control?

Has your child had a _____ vision test _____ Hearing test Results?

Has your child had regular dental checkups? _____ Any dental problems?

Is your child taking any regular medication? _____ If so, please describe:

Does your child have any dietary restrictions? _____ If so, please describe and indicate if this is because of allergy, family preference, medical needs, other?

Describe your child's eating habits: _____ Likes lots of foods _____ Eats only a few foods _____ Eats only at meal times _____ Snacks all day _____ Eats at meal time and snack time

Describe your child's overall health:

Please provide any additional information you think might be important:

Does your child have allergies? _____ Yes _____ No

If yes, please explain. If your child has allergies, please explain his/her reaction

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