

**MT. CARMEL PRESCHOOL
5100 S. OLD PEACHTREE ROAD
NORCROSS, GA 30092
P.O. BOX 922997, NORCROSS, GA 30010
(770) 449-4498
mtcarmelpres@comcast.net**

**FALL 2018
TUITION BREAKDOWN**

There is a non-refundable registration fee of \$100.00 per child and a registration fee of \$50.00 for the second child. There is also a one-time \$75.00 activity fee per child to be paid in August.

T/Th Toddlers - \$188.00 per month (must be 12+ months and walking)
9:30-1:30
5:2 student /teacher ratio

Two's - \$158.00 per month (must be 2 by September 1st)
Days available – **T/Th** or **W/F** 9:30-1:30
8:2 student/teacher ratio

Third, fourth or fifth day available upon request and dependent upon availability

Three's T-F - \$269.00 per month (must be potty trained and 3 by September 1st)
M-F - \$320.00 per month 9:30-1:30
10:2 student/teacher ratio

Fours M-F - \$320.00 per month (must be 4 by September 1st)
Days available – **M-F** 9:30-1:30
12:2 student/teacher ratio

- *For everyone's convenience tuition for the year is divided into 9 equal parts so that tuition stays the same despite "short" and "long" months.*

ENROLLMENT AGREEMENT

YEAR – 2018-2019

CLASS –Todd 2s 3s 4s
Days of the Week _____

Full name of child _____

Name child is called _____ Birthdate _____

Parent’s Names _____

Email Address(s) _____
(for preschool correspondence—please don’t put one if you do not read it)

Mailing Address _____ Zip _____

Home phone _____ cell/work phone, parent _____
(circle one)
cell/work phone, parent _____

For Emergency Purposes:

Physician _____ phone _____

Friend or relative _____ phone _____

Names and phone numbers of persons who may pick your child up from school:

Name _____ Phone _____

Name _____ Phone _____

Acceptance of this enrollment form and the non-refundable registration fee of **\$100/\$50.00** assures your child a place in our program. In return, we expect that you will honor your enrollment for the term. We also ask that you provide your child’s immunization record.

I have read and understand the enrollment terms and agree to abide by these policies. I agree to honor this enrollment and in case I do need to remove my child from the program, I will give two month’s notice or pay for that time. We are also an exempt church school facility and are not licensed by or required to be licensed by the State of Georgia and we do not carry liability insurance.

May 31, 2018 marks the last day of tuition reimbursement if you withdraw for the fall term.

Date _____ Signed _____
(parent or legal guardian)

Amount of registration fee \$ _____ Monthly fee \$ _____

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FIELD TRIP PERMISSION SLIP

AND

RELEASE AGREEMENT

My child, _____, a student at Mt. Carmel Preschool, has been given the opportunity to participate in a number of trips and activities made available for the Preschool. In consideration of my child's being allowed to participate in these trips and activities scheduled from September, 2018 through May, 2019, my child and I hereby release Mt. Carmel Preschool and its staff from any liability with respect to any damage to person or property of any type arising from or relating to activities on said Preschool activities or trips. I hereby give express permission for my child to participate in any or all said trips.

I also authorize the Preschool Director, or any Mt. Carmel Preschool staff member who will participate in any trip or activity, to obtain on behalf of my child, at my expense, any necessary emergency medical treatment services which may be required at any time during said trips.

I HAVE READ THIS RELEASE AND AGREEMENT CAREFULLY.

Date

Parent or Guardian Signature

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TREATMENT AUTHORIZATION

I am concerned that there be no delay in obtaining medical and/or hospital care and treatment for my child _____ in the event that I am unavailable. I understand that under Georgia law a person standing “in Loco Parentis” may consent to such care and treatment. I declare that the director or any Mt. Carmel Preschool staff person stands and acts in place of me for my child in my absence, and there should be no question about their ability to consent to medical treatment for my child.

Date _____ Signature _____
Relationship _____

Child's Name _____

Parent/Guardian Name _____

MEDICAL INFORMATION

Health Insurance Company _____
Group and Policy Number _____

Allergies, if any (food/airborne/other) _____
(please circle type)

Medicines taken regularly, if any _____

Other health problems/conditions, if any _____

Physician's Name _____

Physician's Address _____

FAMILY INFORMATION

You can help us plan for your child's needs, understand his concerns and responses, and support and encourage him by providing the following information. The information will remain confidential, and we hope you will update it when needed.

Child's Name _____

Parent's Names _____

Marital Status of Parents:

_____ Married, living together _____ Separated _____ Divorced

If divorced, please describe custody and visitation agreement for the child (provide copies of legal documents if possible)

Others in your household

Sisters/Brothers, names and ages

Other adults, names and relationship to child

Other significant persons in your child's life (stepfamilies, grandparents, babysitters, etc.) Please give ages of children listed

Names

Relationship to child

Does your child have a pet? (Type and name) _____

Have there been births, deaths, adoptions, or other changes in the family structure which affected your child? If so, describe briefly what happened and the effect on your child.

Do you have any speech or behavioral concerns?

Does your child have the opportunity to play with other children? Y / N

Do you consider your child hard to manage or easily managed?

What methods of discipline have you found most effective for your child?

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

How much sleep does your child require daily? _____ hours

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

Communicable diseases your child has had:

| | No | Yes | If yes, date or age |
|----------------|-------|-------|---------------------|
| Chicken pox | _____ | _____ | _____ |
| Impetigo | _____ | _____ | _____ |
| Conjunctivitis | _____ | _____ | _____ |
| Fifth disease | _____ | _____ | _____ |

Does your child have any abnormality of:

| | No | Yes | If yes, please describe |
|----------------|-------|-------|-------------------------|
| Skin | _____ | _____ | _____ |
| Glands | _____ | _____ | _____ |
| Extremities | _____ | _____ | _____ |
| Nervous system | _____ | _____ | _____ |

Is your child taking any medication regularly? Yes/No
If yes, please describe.

Does your child have any dietary restrictions? Yes/No
If yes, please describe.

Are dietary restrictions due to allergy, family preference, medical needs, other?

Please give any additional information that you think might be important for us to have and please attach a copy of their most recent immunization record.