

Epiphany Preschool Registration Form 2010-2011

Church of the Epiphany
3301 Hidden Meadow Drive, Herndon 20171
(703) 481-8601 ext.116

A non-refundable registration fee and last month's tuition are due at the time of registration.

Registration Fee ~ \$80.00 or max \$150 per family

1-Day \$100 / 2-Days \$200 / 3-Days \$270 / 3 Days Extended \$325 / 4-Days \$320 / 4 Days Extended \$375

RETURNING STUDENT: INFORMATION ON FILE

Class (Please circle) 1-Day 2-Days 3-Days 3-Days Extended Week 4-Day 4-Days Extended Week

Reg. Fee \$ _____

Check # _____

Date _____ Previous School Year Class and Teacher: _____

Child's Name: _____ Name you want the child to be called in school: _____

Date of Birth ____/____/____ Male Female Home Phone: () _____

Address: _____ City: _____ State _____

Zip: _____ Subdivision: _____

Primary language spoken at home (please circle): Chinese English German Korean Spanish OTHER: _____

Father Information

Full Name: _____

Occupation: _____

Bus. Phone: _____

Cell Phone: _____

Address (If Not Child's): _____

Email address: _____

Mother Information

Full Name: _____

Occupation: _____

Bus. Phone: _____

Cell Phone: _____

Address (If Not Child's): _____

Email address: _____

Emergency Information

*Please list two local people (other than parents) to contact in case of an emergency when parents can not be reached.
If English is not your primary language, one of your contacts must speak English.*

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone () _____ Phone: () _____

Alternate Phone: () _____ Alternate Phone: () _____

Any Changes to Child Information

Please only list information that has changed from previous school year.

FAMILY LIFE

Adults who live in the home:

Siblings and their Ages:

Pets and their Names:

MEDICAL

Does your child have any allergies? YES NO

If yes, please describe the allergy and possible reactions: _____

Is an 'Epi-Pen' or Benadryl needed for allergies? YES NO

Does your child have any food restrictions? YES NO If yes, please be specific: _____

Does your child have any other medical conditions (asthma/diabetes/ epi-pen) which the Preschool should be aware of? YES NO If yes please be specific:

Will your child require medication to be kept at School? YES NO If yes, please list the medication(s) below: _____

The Preschool has my permission to list my child's name and our family's name, address, telephone number(s), and e-mail address in a directory provided to Preschool families. YES NO

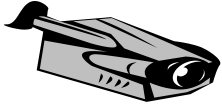
Preschool families are invited to participate in all Church of the Epiphany activities. Would your family like to be included in the Epiphany Candle E-Mail distribution list and other mailings? YES NO

All information on this form will be kept confidential.

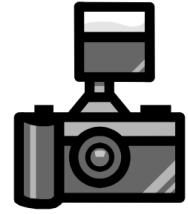
I have read the Parent Handbook (go online to www.epiphanypreschool.org) and agree to abide by the policies and procedures stated within.

Signature of Parent/Guardian

Date



Photo/Video Permission and Release Form



Epiphany Preschool has my permission to include my child, _____, in any photographs and/or videotapes taken during Epiphany Preschool 2010-2011 school year activities. I further understand these photos and/or videos may be shared with staff, parents, Church of the Epiphany web page browsers, and others for the purpose of education, training, and presenting the school's programs.

Parent Full Name (*Please Print*) _____

Parent Signature: _____ Date: _____

I am requesting that my child, _____, **NOT** be included in any photographs or videotapes taken during Epiphany Preschool 2010-2011 school year **for use outside** of Epiphany Preschool.

Parent Full Name (*Please Print*) _____

Parent Signature: _____ Date: _____

I am requesting that my child, _____, **NOT** be included in **any** photographs or videotapes taken during Epiphany Preschool 2010-2011 school year.

Parent Full Name (*Please Print*) _____

Parent Signature: _____ Date: _____



Authorization for Emergency Treatment

I, _____, hereby authorize any physician
 (PARENT OR GUARDIAN)
 member of the Department of Emergency Medicine of Fair Oaks Hospital, Fairfax Hospital, Emergency Care Center of Reston / Herndon, and Mount Vernon Hospital or any member of the Medical Staffs of the Above mentioned hospitals requested by the Department of Emergency Medicine physician, to render medical treatment, which in his/her judgment may be deemed necessary in the care of

 (NAME OF CHILD OR DEPENDENT)

Child's Date of Birth: _____

Child's Allergies (if any): _____

Child's Dr.: _____ Telephone #: _____

Family Dr.: _____ Telephone #: _____

Medicines Child is taking: _____

Date of Last Tetanus Shot: _____

Outstanding Medical History (ex. Diabetes, Heart Disease, etc.): _____

Insurance Information

Insurance Company: _____

Identification / Policy No.: _____

Subscriber's name: _____

Subscriber's Place of Employment: _____

Subscriber's Telephone No.: _____

ALL PARENTS AND GUARDIANS ARE RESPONSIBLE FOR MAINTAINING THIS CONSENT FORM AS IT CANNOT BE MAINTAINED BY THE HOSPITAL.

 DATE

 SIGNATURE OF PARENT OR GUARDIAN

EPIPHANY PRESCHOOL EMERGENCY CARE INFORMATION

Student's Full Name _____

Date of Birth _____ (Please circle) Boy Girl

Home Address _____

Mother's Name _____ Father's Name _____

Home # _____ Home # _____

Work # _____ Work # _____

Cell# _____ Cell# _____

Local Emergency Contact (other than parent)

1. Name & Relationship _____

Home # _____ Cell # _____

2. Name & Relationship _____

Home # _____ Cell # _____

MEDICAL INFORMATION

List any medications taken regularly and adverse effects:

List any allergies and accompanying reactions:

Is the student under a physician's continuing care? If yes, please explain:

The school has my permission in an emergency when I and my emergency contact cannot be reached, to send my child to the emergency room of the nearest hospital, and the hospital and its' medical staff have my authorization to provide any treatment which a physician deems necessary for the well-being of my child.

Parent Signature _____ Date _____