

# Learning Place Preschool

8576 Veterans Memorial Pkwy. O'Fallon, MO 63366  
Phone: 636-978-1133; FAX: 636-978-2511

Days Requested (2 & 4 Day Sessions Available For All Ages) M/W, T/TH, M-TH; Pre-K ONLY: T-TH

Child's Full Name: \_\_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

First

Middle

Last

What school district do you live in? \_\_\_\_\_

What elementary school will your child attend for kindergarten? \_\_\_\_\_

OTHER PERSONS AUTHORIZED TO TAKE CHILD FROM PRESCHOOL, PLEASE LIST AT LEAST TWO.

NAME/RELATIONSHIP	Phone #	NAME/RELATIONSHIP	Phone #
NAME/RELATIONSHIP	Phone #	NAME/RELATIONSHIP	Phone #
NAME/RELATIONSHIP	Phone #	NAME/RELATIONSHIP	Phone #
NAME/RELATIONSHIP	Phone #	NAME/RELATIONSHIP	Phone #

Family's Religious Preference/Church Affiliation: \_\_\_\_\_

Names & Birthdates of Brothers & Sisters:

1) \_\_\_\_\_ 2) \_\_\_\_\_  
3) \_\_\_\_\_ 4) \_\_\_\_\_

How did you hear about us? Internet, Drive by, Friend/Family, Other: \_\_\_\_\_

FOR OFFICE USE ONLY:

Amount Received. \$ \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Check  Money Order  Cash; Check # \_\_\_\_\_

Received by: \_\_\_\_\_

Dad's E-Mail Address: \_\_\_\_\_

Mom's E-Mail Address: \_\_\_\_\_

Additional Notes: \_\_\_\_\_

Child's Parents Are:  Married  Divorced/Separated  Not Married

Child Primarily Lives With:  Both Parents  Mother  Father  Other : \_\_\_\_\_

If Other, Name: \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Phone #'s \_\_\_\_\_

### **Payment Agreement:**

The **non-refundable** enrollment fee is due, along with the completed Registration Form Part 1, to hold your child's spot in class; Part 2 is due by the first day of class. The monthly tuition is due by the 1st of each month. The first payment is due no later than September 1. A late fee of \$5 a day will be assessed each business day a payment is late, for each child enrolled. If payment is not received by the fourth day of your child's school session, your child will no longer be able to attend until all payments have been made current. In December school may be out of session earlier, if so, that payment will be due at an earlier date, sometime before Christmas break. We will make every effort to alert parents of that date in the Open House handout, December's classroom newsletter and postings within the building. The terms of this agreement will still be imposed, using that alternate payment date. There will also be an activity/parties fee (to make it easier on parents during party times). All payments should be made by check or money order, but we will accept cash. Checks that are returned by the bank unpaid will be assessed a \$25 fee, along with any late fees. **We do not take credit/debit card payments as we are unable to process them.**

**Please make checks payable to: Learning Place Preschool.**

Payment Responsibility?  Mother  Father  Parents to Share  Other : \_\_\_\_\_

(Check all that apply; If child lives with both parents, just check the person who would most likely be making the monthly payment.)

**If the payment is shared between two different individuals, each person responsible must sign this agreement:**

I, (your name) \_\_\_\_\_ agree to pay tuition and other fees for \_\_\_\_\_ (Child's first and last name)

in the following percent or dollar amount \_\_\_\_\_.

 Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

**IF THE CHILD'S TUITION AND FEES ARE TO BE SHARED, the following agreement must be filled out and signed by the individual who will be responsible for making the other portion of those payments.**

I, (your name) \_\_\_\_\_ agree to pay tuition and other fees for \_\_\_\_\_ (Child's first and last name)

in the following percent or dollar amount \_\_\_\_\_.

Address: \_\_\_\_\_

Phone #'s: \_\_\_\_\_ / \_\_\_\_\_

Email: \_\_\_\_\_

 Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Relationship to Child \_\_\_\_\_



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
SECTION FOR CHILD CARE REGULATION  
**CHILD CARE ENROLLMENT FORM FOR LICENSE-EXEMPT FACILITIES**

FACILITY/PROVIDER NAME LEARNING PLACE PRESCHOOL			ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME			GENDER	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)				
<b>IDENTIFYING INFORMATION</b>				
MOTHER'S/GUARDIAN'S NAME			HOME TELEPHONE NUMBER	
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE <input type="checkbox"/>			CELL PHONE NUMBER	
E-MAIL ADDRESS				
EMPLOYER OR SCHOOL ATTEND			WORK/SCHOOL SCHEDULE	
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)			WORK TELEPHONE NUMBER	
FATHER'S/GUARDIAN'S NAME			HOME TELEPHONE NUMBER	
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE <input type="checkbox"/>			CELL PHONE NUMBER	
E-MAIL ADDRESS				
EMPLOYER OR SCHOOL ATTEND			WORK/SCHOOL SCHEDULE	
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)			WORK TELEPHONE NUMBER	
<b>EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY</b> (OTHER THAN PARENT) AT LEAST ONE EMERGENCY CONTACT IS REQUIRED.				
NAME		RELATIONSHIP TO CHILD		TELEPHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)				
NAME		RELATIONSHIP TO CHILD		TELEPHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)				
<b>AUTHORIZATION FOR EMERGENCY MEDICAL CARE</b>				
I UNDERSTAND THAT I WILL BE NOTIFIED AT ONCE IN CASE OF AN EMERGENCY WITH MY CHILD, AND I WILL MAKE ARRANGEMENTS FOR MEDICAL CARE OF MY CHILD WITH THE PHYSICIAN OR HOSPITAL OF MY CHOICE.				
IF I CANNOT BE REACHED TO MAKE NECESSARY ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZE				
Learning Place Preschool DAY CARE PROVIDER				
TO CONTACT THE FOLLOWING:				
<b>PHYSICIAN OR CLINIC</b>				
NAME			TELEPHONE NUMBER	
<b>PREFERRED HOSPITAL</b>				
NAME			TELEPHONE NUMBER	

## ACKNOWLEDGEMENTS

A	I HAVE BEEN INFORMED OF THE REQUIRED HEALTH AND SAFETY INSPECTIONS AND THE INSPECTION FORMS ARE AVAILABLE FOR REVIEW.	PARENT/GUARDIAN INITIALS
B	WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT S/HE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE.	PARENT/GUARDIAN INITIALS
C	I <input type="checkbox"/> DO <input type="checkbox"/> DO NOT GIVE PERMISSION FOR FIELD TRIPS/EXCURSIONS. I UNDERSTAND I WILL BE NOTIFIED IN ADVANCE WHEN THEY ARE PLANNED.	PARENT/GUARDIAN INITIALS
D	I <input type="checkbox"/> DO <input type="checkbox"/> DO NOT GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD.	PARENT/GUARDIAN INITIALS
E	I HAVE BEEN NOTIFIED THAT I MAY REQUEST NOTICE AT INITIAL ENROLLMENT OR ANY TIME THERE AFTER WHETHER THERE ARE CHILDREN CURRENTLY ENROLLED IN OR ATTENDING THE FACILITY FOR WHOM AN IMMUNIZATION EXEMPTION HAS BEEN FILED.	PARENT/GUARDIAN INITIALS

## **HEALTH REPORT FOR SCHOOL-AGE CHILD CHILD'S HEALTH HISTORY AND CURRENT HEALTH PROBLEMS**

MY CHILD IS IN GOOD HEALTH, IS ABLE TO PARTICIPATE IN GROUP CARE, HAS NO SPECIAL HEALTH OR MEDICAL REQUIREMENTS.

MY CHILD IS ABLE TO PARTICIPATE IN GROUP CARE BUT HAS SPECIAL HEALTH OR MEDICAL REQUIREMENTS AS LISTED BELOW.

**ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS**

**ANY SPECIAL MEDICATIONS AND/ OR RESTRICTIONS**

**PARENT/GUARDIAN SIGNATURE**

DATE

FORM TO BE RETAINED FOR ONE YEAR AFTER DISCHARGE.

**FILING:** FILE FORM IN CHILD'S INDIVIDUAL RECORD.