

ADVENT CHRISTIAN KINDERGARTEN
1601 Green Lane
West Chester, PA 19382

Please Print Clearly:

CHILD'S NAME: _____

NICKNAME: _____

DOB: _____
Month/day/year

ADDRESS: _____

_____ city state zip code

HOME PHONE #: _____ CELL PHONE #: _____

EMAIL ADDRESS: _____

PARENTS' NAMES: _____

SIBLINGS NAMES & AGES: _____

HOW WILL YOUR CHILD BE TRANSPORTED TO ADVENT? _____

I give permission for my mailing information/phone number to be included in the class directory:

PARENT/GUARDIAN SIGNATURE DATE

SIGNATURE DATE:

**REMINDER: NO REGISTRATION WILL BE ACCEPTED WITHOUT THE NON-REFUNDABLE
REGISTRATION FEE OF \$60.00 PLUS THE FIRST MONTH'S TUITION!**

[For office use only:]

CHECK #: _____ AMOUNT RECEIVED: \$ _____

DATE REGISTERED: _____

ADVENT CHRISTIAN KINDERGARTEN
1601 Green Lane ~ West Chester, PA 19382
Email: adventprek@yahoo.com 610-436-0138
Luci Keeler ~ Director
www.e-advent.org [click on Advent Christian Kindergarten]
Tax ID #: 23-6436015

Advent Christian Kindergarten Tuition Policy and School Agreement

- I understand that I must review and sign the policy below concerning tuition.
- I understand that in order for my child to be a registered student I must include:
 - ❖ a \$60.00 registration fee AND the first month's tuition.
- Tuition is broken into nine monthly payments starting with payment #1 when you register in August and continues monthly until April 15th [payment #9].
- I understand that I may pay tuition semi-annually in August and January or annually in August.
- I have read and understand the tuition payment plan policy.
- By signing below I understand and agree to the tuition statements and policies outlined by Advent Christian Kindergarten.
- I understand that I must provide a copy of my child's birth certificate and immunization records prior to the start of school.**

Parent Name: _____ Date: _____

Please print clearly

Parent Signature: _____ Date: _____

Director Signature: _____ Date: _____

Please return with your child's registration forms and fees.

EMERGENCY CONTACT INFORMATION

Child's Name	
Birth Date	
Street Address	
City, State, Zip Code	
Home Phone #	

Sibling[s] Name	Birth Date	Living in Child's Home [Y/N]

Mother's/Guardian's Name	
Home Street Address	
City, State, Zip Code	
Home Phone	
Home E-Mail	
Work Street Address	
City, State, Zip Code	
Work Phone	
Work E-Mail	
Pager Number	
Cellular Phone	
Other [please specify]	

Father's/Guardian's Name	
Home Street Address	
City, State, Zip Code	
Home Phone	
Home E-Mail	
Work Street Address	
City, State, Zip Code	
Work Phone	
Work E-Mail	
Pager Number	
Cellular Phone	
Other [please specify]	

[continued on back]

Please list two people who can be contacted in an emergency if the parent[s] or guardian[s] cannot be reached:

1st Alternate Contact	
Relationship to child	
Home Street Address	
City, State, Zip Code	
Home Phone	
Home E-Mail	
Work Street Address	
City, State, Zip Code	
Work Phone	
Work E-Mail	
Pager Number	
Cellular Phone	
Is this person authorized to make medical decisions for your child if you cannot be reached? Yes ____ No ____	

2nd Alternate Contact	
Relationship to child	
Home Street Address	
City, State, Zip Code	
Home Phone	
Home E-Mail	
Work Street Address	
City, State, Zip Code	
Work Phone	
Work E-Mail	
Pager Number	
Cellular Phone	
Is this person authorized to make medical decisions for your child if you cannot be reached? Yes ____ No ____	

Child's Physician or Name of Clinic	
Preferred Practitioner	
Street Address	
City, State, Zip Code	
Telephone Number	

Child's Dentist or Name of Clinic	
Preferred Practitioner	
Street Address	
City, State, Zip Code	
Telephone Number	

PERMISSION FOR HEALTH CARE

Child's Name: _____ Date: _____

Child's Physician: _____ Phone #: _____

Address: _____

Child's Dentist: _____ Phone #: _____

Address: _____

AUTHORIZED ADULTS:

In the event of an emergency, please indicate your name and phone number where you and another authorized person can be reached while your child is at school from noon-3 pm.

Father's Name: _____ Phone #: _____

Mother's Name: _____ Phone #: _____

Another Authorized Person: _____

Phone #: _____ Relationship to Child: _____

Address: _____

FIRST AID:

In the event of an emergency, I authorize the staff to provide any first aid care deemed necessary for my child.

Parent/Guardian Signature

Date

EMERGENCY CARE:

In the event of an emergency in which I cannot be reached, the physician listed above and the local hospital are hereby authorized to provide any emergency care deemed necessary for my child.

Parent/Guardian Signature

Date

CHILD PICK-UP AUTHORIZATION FORM

COMPLETE THIS FORM & RETURN IT TO THE DIRECTOR
PLEASE PRINT CLEARLY

I, _____ authorize Advent Christian
Preschool to release my child[ren] to the person[s] designated below. This is in consonance
with the Advent Christian Preschool Emergency Plan.

Child's Name: _____ **Designated Custodian[s] Name & Relationship** _____

***NOTE:** Parents and Guardians should designate themselves as designated custodians.
Other relatives, friends and neighbors may also be designated.*

_____	_____
_____	_____
_____	_____
_____	_____

Your Signature

Relationship

Date

Print Name

Street Address

City

State

Zip Code

Contact Phone Numbers:

Home: _____

Mother's Work: _____

Father's Work: _____

Mother's Cell: _____

Father's Cell: _____

Kindergarten Parent Survey

Please print clearly

Child's Name _____

Nickname _____

Birth date _____

Month/Day/Year

Address _____

City

State

Zip code

Home Telephone [including area code] _____

Names & Ages of Siblings _____

Household pets/pets' name[s] _____

The information below will help us provide a better school experience for your child.

Did your child attend preschool or day care? ____ Yes ____ No

If yes, please list name(s) of preschool(s): _____

What language(s) is/are primarily spoken in your home? _____

Does your child have any specific fears? _____

Does your child have any special interests? [dance, music, sports, etc.] _____

Please list any allergies/health concerns

What are you hoping to have your child gain from this experience?

Is there any information to help us know your child better?

Is your child currently receiving services from an outside agency (speech, language, etc.)?

Yes No

If yes, please list services and provider: _____

Does your child have an IEP? _____