PRESCHOOL APPLICATION

GOOD SHEPHERD PRESCHOOL PROGRAM

#300601001

8152 MC FADDEN AVENUE, WESTMINSTER, CALIFORNIA 92683 (714) 894-4330 www.goodshepherdwestminster.com

_____

MONTH/YEAR

CIRCLE DAYS/TIMES CHILD WILL ATTEND:

MON TUE WED THURS FRI

HALF DAY 9:00am-12:00pm FULL DAY 6:30am-6:00pm

TUITION CHARGED FOR THE PRESCHOOL PROGRAM IS BASED ON YOUR SELECTED NUMBER OF DAYS AND TIMES AND IS BILLED MONTHLY. THE DAYS THE SCHOOL IS CLOSED HAVE NOT BEEN INCLUDED IN YOUR COST. FAMILIES WILL QUALIFY AFTER 6 MONTHS OF CONTINUED ENROLLMENT FOR CREDIT EQUAL TO AN AVERAGE WEEK TO BE USED AS VACATION/SICK DAYS PERIOD. STUDENTS MUST CONTINUE THEIR ENROLLMENT UNTIL JUNE AT WHICH TIME THE CREDIT WILL BE APPLIED. PAPERWORK MUST BE FILLED OUT AT THE TIME OF ABSENCE.

(Please Print)

Child's Name_____Birthdate:_____
Last Name First Name Middle Name

Home Number_____Church Affiliation_____

Full Names of Father & Mother or Guardian_____

Home Address_____City_____Zip_____-_____

Marital Status ( ) Married ( ) Divorced ( ) Widowed ( ) Other_____

Names & ages of other children in family_____

Has child attended preschool before?_____How long?_____Where?_____

Father's Occupation_____Company_____

Social Security #_____Business Phone_____Ext_____Cell Phone_____

Business Address_____

Mother's Occupation_____Company_____

Social Security #_____Business Phone_____Ext_____Cell Phone_____

Business Address_____

Child's Physician_____Address_____Phone_____

FIELD TRIP AND MEDICAL CONSENT

I do hereby authorize Good Shepherd Preschool to take_____on any field trip whose plans have been posted. Parents will be issued a separate consent form for each field trip. In the event that my child becomes ill or sustains an injury while in the care of Good Shepherd Preschool, I give my permission to those in charge to take whatever steps are necessary to stop any bleeding. If it is not possible to reach the doctor named above or to receive my instructions for his/her care, consent is given to any licensed physician and/or surgeon called upon to whom my child is taken for treatment by them or to administer drugs or medications and perform such surgical procedures as he shall think the emergency requires for the relief of pain and to preserve his/her life and health. I will be responsible for all expenses incurred by such an illness or injury.

PARENT SIGNATURE REQUIRED_____DATE_____