TRINITY LUTHERAN PRESCHOOL
110 High St. Ashaway, RI 02804
(401) 377-4216
Lori S. Calcagni Preschool Director

Student Registration Form

Date of Enrollment:_____

Child's Name:_____
Date of Birth:_____
Mother's Name:_____
Address:_____
Mailing Address:_____
Phone:_____
Father's Name:_____
Address:_____
Mailing Address:_____
Phone:_____
Email address:_____
Child lives with: Mother____ Father____ Both_____Other_____(specify)
Previous Preschool Experience:_____
_____

I would like to enroll my child in:
Check the following days and hours you would like your child to attend. A minimum of **two** days per week is required. A full day is considered 8 am to 3:30 pm. A half day is 8:45 am to 11:30 am.

	Full day	AM
Monday	_____	_____
Tuesday	_____	_____
Wednesday	_____	_____
Thursday	_____	_____
Friday	_____	_____

A $75.00 registration fee is due with this registration. (non-refundable) Please make check payable to Trinity Lutheran Preschool.

Parent Signature:_____
Date:_____

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PARENT AUTHORIZATION FOR EMERGENCY TREATMENTS

In consideration for admittance, I_____, hereby authorize Trinity Lutheran Preschool to arrange for medical treatment of my child _____ should an emergency arise at school or on a fieldtrip. It is understood that conscientious effort will be made by the school to contact me at the emergency numbers I have provided below before medical action is taken. I would prefer to have my child taken to_____ . Hospital. I understand that the choice of hospital may be limited by service of local rescue squad.

Health Insurance:_____
Policy #:_____ Expires:_____

Parent or Guardian Signature:
Home Phone:_____
Work: _____
Cell:_____

Relative or other persons to contact in an emergency:

Name:_____ Name:_____
Address: _____ Address:_____
_____
Phone: _____ Phone:_____
Relation to child:_____ Relation to child:_____