

**HPC Preschool**  
*A Ministry of Huntersville Presbyterian Church*  
**2018-2019 Registration Form**

Check #: _____
Date Rec'd: _____
Class Placement: _____
Waiting List #: _____
Notified: _____
<b>(For Office Use Only)</b>

Name of Child: \_\_\_\_\_  

(Last)
(First)
(Middle)
(Name Called)

Age of Child: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Gender: \_\_\_\_\_

Parent(s) Full Name: \_\_\_\_\_

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

(Street/P.O. Box)
(City)
(State)
(Zip Code)

Primary Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

\_\_\_\_\_ **Currently Enrolled Student/Sibling**      \_\_\_\_\_ **Church Member**      \_\_\_\_\_ **Public**

*A non-refundable yearly registration fee of \$75 must accompany this registration form. (Additional siblings \$65)*

*Registration is not valid without this registration fee.*

*Each child pays a registration fee to hold a space, cover supplies and insurance.*

*If a child is placed on a waiting list, the registration fee will be refunded.*

*HPC Preschool reserves the right to cancel any classes that do not meet the minimum class size.*

*Please make checks payable to HPC Preschool.*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Part-time Preschool Programs (September through May)**

- |                 |   |            |
|-----------------|---|------------|
| <u>        </u> | <b><u>Two Year Old Class</u></b> (Must be 2 years old on or before August 31, 2018)               | 2:12 Ratio |
|                 | Tuesday/Thursday      9:00 a.m. - 1:00 p.m.      \$180/Month                                      |            |
| <u>        </u> | <b><u>Three Year Old Class</u></b> (Must be 3 years old on or before August 31, 2018)             | 2:14 Ratio |
|                 | Monday/Wednesday/Friday      9:00 a.m. - 1:00 p.m.      \$210/Month                               |            |
| <u>        </u> | <b><u>Three Year Old Class</u></b> (Must be 3 years old on or before August 31, 2018)             | 2:14 Ratio |
|                 | Tuesday/Thursday      9:00 a.m. - 1:00 p.m.      \$180/Month                                      |            |
| <u>        </u> | <b><u>Four Year Old Class</u></b> (Must be 4 years old on or before August 31, 2018)              | 2:16 Ratio |
|                 | Monday through Thursday      9:00 a.m. - 1:00 p.m.      \$240/Month                               |            |
| <u>        </u> | <b><u>Four Year Old Class</u></b> (Must be 4 years old on or before August 31, 2018)              | 2:16 Ratio |
|                 | Monday/Wednesday/Friday      9:00 a.m. - 1:00 p.m.      \$210/Month                               |            |
| <u>        </u> | <b><u>Transitional Kindergarten Class</u></b> (Must be 5 years old on or before January 15, 2019) | 2:16 Ratio |
|                 | Monday through Friday      9:00 a.m. - 1:00 p.m.      \$300/Month                                 |            |

~Contact 704-875-7756 or [mbryant@hpcpatch.org](mailto:mbryant@hpcpatch.org) for more information~



# Children's Medical Report

P.O. Box 313  
Huntersville, NC 28070  
704-875-7756 (Phone)  
704-948-5611 (Fax)

Name of Child \_\_\_\_\_ Birthdate \_\_\_\_\_  
Name of Parent or Guardian \_\_\_\_\_  
Address of Parent or Guardian \_\_\_\_\_

### A. Medical History (May be completed by parent/guardian)

1. Is child allergic to anything? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, what? \_\_\_\_\_
2. Is child currently under a doctor's care? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, for what reason? \_\_\_\_\_
3. Is the child on any continuous medication? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, what? \_\_\_\_\_
4. Any previous hospitalizations or operations? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, when and what for? \_\_\_\_\_
5. Any history of significant previous diseases or recurrent illness? No \_\_\_\_\_ Yes \_\_\_\_\_ **Diabetes?** No \_\_\_\_\_ Yes \_\_\_\_\_ ;  
**Convulsions?** No \_\_\_\_\_ Yes \_\_\_\_\_ ; **Heart Trouble** No \_\_\_\_\_ Yes \_\_\_\_\_ ; **Asthma** No \_\_\_\_\_ Yes \_\_\_\_\_  
If others, what/when? \_\_\_\_\_
6. Does the child have any physical disabilities: No \_\_\_\_\_ Yes \_\_\_\_\_ if yes, please describe: \_\_\_\_\_  
Any mental disabilities? No \_\_\_\_\_ Yes \_\_\_\_\_ if yes, please describe: \_\_\_\_\_

**Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

### This section to be completed by the pediatrician:

B. Physical Examination: This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the N.C. Board of Medical Examiners (or a comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting DEHNR standards for EPSDT program.

Height \_\_\_\_\_ % Weight \_\_\_\_\_ %  
 Head \_\_\_\_\_ Eyes \_\_\_\_\_ Ears \_\_\_\_\_ Nose \_\_\_\_\_ Teeth \_\_\_\_\_  
 Throat \_\_\_\_\_ Neck \_\_\_\_\_ Heart \_\_\_\_\_ Chest \_\_\_\_\_ Abd/GU \_\_\_\_\_  
 Ext \_\_\_\_\_ Neurological System \_\_\_\_\_ Skin \_\_\_\_\_ Vision \_\_\_\_\_ Hearing \_\_\_\_\_  
 Results of Tuberculin Test, if given: Type \_\_\_\_\_ Date \_\_\_\_\_ Normal \_\_\_ Abnormal \_\_\_\_\_  
 Should activities be limited? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, explain \_\_\_\_\_  
 Any other recommendations: \_\_\_\_\_

Developmental Evaluation: delayed \_\_\_\_\_ age appropriate \_\_\_\_\_  
 If delay, note significance and special care needed: \_\_\_\_\_

Should activities be limited? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, explain: \_\_\_\_\_

**Date of Examination:** \_\_\_\_\_

**Signature of authorized examiner/title** \_\_\_\_\_ **Phone #** \_\_\_\_\_





HPC Preschool  
201 S. Old Statesville Road  
P.O. Box 313  
Huntersville, NC 28070  
704-875-7756

# Emergency Form

This document is to certify that for the period of time my child is enrolled in any of the Huntersville Presbyterian Church Child Care Programs that:

I hereby constitute and appoint:

**The Staff of the Huntersville Presbyterian Church Child Care Program**

*The power to authorize medical treatment and the performance of any procedure determined to be necessary after consultation with the emergency room or family physician, on my child/children in my absence.*

Child's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Allergies/Problems: \_\_\_\_\_ Date of last Tetanus: \_\_\_\_\_

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

Father's Name: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Place of Business: \_\_\_\_\_ Phone #: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Place of Business: \_\_\_\_\_ Phone #: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

Is your child covered by family/medical hospital insurance? \_\_\_\_\_

If yes, indicate carrier or plan name: \_\_\_\_\_ Group Policy #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTARIZED BY:**

I certify that \_\_\_\_\_ appeared before me this day, and I acknowledge signing the foregoing document.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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

Seal:

