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

HPC Preschool

A Ministry of Huntersville Presbyterian Church

2019-2020 Registration Form

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)

_____ **Two Year Old Class** (Must be 2 years old on or before August 31, 2019) 2:12 Ratio
Tuesday/Thursday 9:00 a.m. - 1:00 p.m. $180/Month

_____ **Three Year Old Class** (Must be 3 years old on or before August 31, 2019) 2:14 Ratio
Monday/Wednesday/Friday 9:00 a.m. - 1:00 p.m. $210/Month

_____ **Three Year Old Class** (Must be 3 years old on or before August 31, 2019) 2:14 Ratio
Tuesday/Thursday 9:00 a.m. - 1:00 p.m. $180/Month

_____ **Four Year Old Class** (Must be 4 years old on or before August 31, 2019) 2:16 Ratio
Monday through Thursday 9:00 a.m. - 1:00 p.m. $240/Month

_____ **Four Year Old Class** (Must be 4 years old on or before August 31, 2019) 2:16 Ratio
Monday/Wednesday/Friday 9:00 a.m. - 1:00 p.m. $210/Month

_____ **Transitional Kindergarten Class** (Must be 5 years old on or before January 15, 2020) 2:16 Ratio
Monday through Friday 9:00 a.m. - 1:00 p.m. $300/Month

~Contact 704-875-7756 or mbryant@hpcpatch.org for more information~

Return this form 30 days after the first day of school.

Children's Medical Report

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 #** _____

Immunization History

Name: _____ Date of Birth _____

Enter the date an immunization was received in the space below or attach a copy of the immunization record. G.S. 130A-155(b) requires all child care facilities to have this information on file.

Enter date of each dose - Month/Day/Year

VACCINE	#1	#2	#3	#4	#5
*DTP/DT (Circle which)					
*Polio					
**Hib					
***Hepatitis B					
*MMR (Combined doses)					
****Chicken Pox					
PREVNAR					
OTHER					

* Required by State law.
** Required by State law for children born on or after 10/1/88.
*** Required by State law for children born on or after 7/01/94.
**** Required by State law for children born on or after 4/01/01.

Records Updated by:	Date Updated:

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:

Post Picture of Child Here