



Morning Star Preschool Registration Form

100 Limekiln Road, Bechtelsville, PA 19505

Phone: 610-369-1960 email: preschool@mstar.org

A non-refundable \$50.00 registration fee must accompany each child's registration form.

Student Information:

Child's Name _____ Birth date _____ Boy _____ Girl _____

Child's Address _____ City _____ State _____ ZIP _____

Phone # _____ Is your child potty trained? _____ Yes _____ No _____

Parent/Guardian Information:

Mother's Name _____ Cell # _____
Workplace _____ Phone # _____

Father's Name _____ Cell # _____
Workplace _____ Phone # _____

Other/Guardian Name _____ Cell # _____
Workplace _____ Phone # _____
Relationship to Child _____

Brothers/Sisters:	<u>Name</u>	<u>Age</u>
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Special Needs:

Please describe any medical condition (allergies, surgeries, hearing or speech concerns) or home concerns (ill grandparents, recent divorce, etc.)

I would like to register my child for:

- 2 Year Play and Learn Group on Monday's from 9—10:30am *\$50 per month
- 3/4 Year Old Class on Tuesday's and Thursday's from 9am—12pm *\$90 per month
- 4/5 Year Old Class on Monday, Wednesday and Friday from 9am—12pm *\$120 per month

OFFICE USE ONLY:

Registration Fee Received: Cash \$ _____ Check # _____ Check Amount \$ _____ Date Received _____
Credit/Debit Card _____ Receipt Attached _____

Supplemental Forms Received: Permission Slip /Date Received _____
 Emergency Information Sheet/Date Received _____
 Child Health Assessment / Date Received _____

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Child Health Assessment

Child's Name _____ Parent/Guardian _____
 DOB _____ Address _____
 Child Care Facility/School MSF Preschool
 Child Care Facility/School Phone 610-369-1960 Work Phone _____

Note: A copy of the EPSDT exam report attached to a copy of the child's immunization record may be substituted for this form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND EMERGENCIES:

DATE OF EXAM _____

ALLERGIES TO FOOD OR MEDICINE:

LENGTH/HEIGHT _____ IN/CM %ILE _____	WEIGHT _____ LB %ILE _____	HEAD CIRCUMFERENCE _____ IN/CM %ILE _____	BLOOD PRESSURE _____/_____
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PHYSICAL EXAMINATION	NORMAL	ABNORMAL/COMMENTS
HEAD/EARS/EYES/NOSE/THROAT		
TEETH		
CARDIORESPIRATORY		
ABDOMEN/GI		
GENITALIA/BREASTS		
EXTREMITIES/JOINTS/BACK/CHEST		
SKIN/LYMPH NODES		
NEUROLOGIC/TONE		
DEVELOPMENTAL (E.G. DDST)		

IMMUNIZATIONS	BIRTH TO 1 MO	2 MO	4 MO	6 MO	12-18 MO	4-6 YRS	11-12 YRS
DPT							
POLIO							
HIB							
HEP B							
MMR							
OTHER	Note: Ages and number of boosters may vary when immunization start at older ages.						

SCREENING TEST	DATE	NORMAL	ABNORMAL/COMMENTS
LEAD			
ANEMIA (HGB/HCT)			
URINALYSIS (UA)			
TUBERCULOSIS (TB)			
HEARING			
VISION			

DATE OF LAST DENTAL EXAM _____

Note: Age appropriate health services and immunization must follow the schedule recommended by The American Academy of Pediatrics, 141 Northwest Point Blvd, Elk Grove Village, IL 60007

HEALTH PROBLEMS OR SPECIAL NEEDS

RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE (Attach additional sheets if necessary)

MEDICAL CARE PROVIDER

NEXT APPOINTMENT: MONTH _____ YEAR _____

ADDRESS
PHONE

DATE _____ **SIGNATURE OF PHYSICIAN OR CRNP** _____

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Emergency Information Sheet

EMERGENCY CONTACT INFORMATION

Child's Name _____ Birth Date _____
Parent/Legal Guardian #1 _____ Home # _____ Work# _____ Cell # _____
Parent/Legal Guardian #2 _____ Home # _____ Work# _____ Cell# _____

My child can be released into the custody of **ONLY THE PERSONS LISTED BELOW:**

1. _____ Home # _____ Work# _____ Cell# _____
2. _____ Home # _____ Work# _____ Cell# _____
3. _____ Home # _____ Work# _____ Cell# _____

If parents or legal guardians cannot be reached, who should be called?

Name _____ Relationship to child _____
Home # _____ Work # _____ Cell# _____
Name _____ Relationship to child _____

Child's Physician _____
Address _____ Phone # _____

Child's Health Insurance Co. _____
Name on Card _____ ID # _____

Please list any special conditions, disabilities, allergies, other pertinent medical information _____

If necessary, child will be taken to Pottstown Hospital unless noted otherwise here _____

PARENT/GUARDIAN CONSENT AND AGREEMENT FOR EMERGENCIES:

I give consent to have my child receive first aid by the school's staff, and if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance. I give consent for emergency contact person listed above to act on my behalf until I am available. My child may be released to the contact persons listed on this form. I agree to notify Morning Star Fellowship Preschool of any changes in this information.

Date: _____ Parent/Guardian Signature: _____



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Date: _____ Parent/Guardian Signature: _____

Permission Slip

Name of Child _____

I give my permission to the staff of Morning Star Preschool to take my child outdoors for play or a neighborhood walk on any given day as weather permits.

_____ Signature of the Parent/Guardian

_____ Relationship to Child

_____ Date