WESLEY'S CIRCLE OF FRIENDS PRESCHOOL

2540 Center Street
Bethlehem, PA 18017
(610) 865-5715

REGISTRATION FORM 2022-2023

CHILDS'S FULL NAME _____ Birth Date: _____

Parent/Guardian Name _____ Home Phone: _____

Address _____ Work Phone: _____

_____

Parent/Guardian Name _____ Home Phone: _____

Address _____ Work Phone: _____

_____

Email Address Parent _____ Cell Phone: _____

Parent _____ Cell Phone: _____

When selecting class below, child must meet minimum age requriement as of October 1st of current year

TODDLERS (ages 12 months-23 months) ***9:30AM - 12 PM*** I would like my child to come on these days (pls circle)

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY

TWO' S ***9:30AM-1:30 PM*** I would like my child to come on these days (pls circle)

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY

THREE'S ***9:30AM-1:30PM*** I would like my child to come on these days (pls circle)

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY

FOUR'S ***9:30AM-1:30PM*** I would like my child to come on these days (pls circle)

MONDAY THROUGH FRIDAY

OR

MONDAY/WEDNESDAY/FRIDAY ADD TUESDAY ADD THURSDAY

Extended care is offered from 7:45 AM to 4:00 PM Monday through Friday. I need extended care as follows:

AM starting at _____ AM on the following day(s): M T W TH F

PM ending at _____ PM on the following day(s): M T W TH F

Family and Friends to whom we may release your child, other than parents/guardians listed above

Name _____ Relation _____ Cell #

Name _____ Relation _____ Cell #

Name Relation _____ Cell #

****

EMERGENCY INFORMATION

In case of an emergency and parent/guardian cannot be reached, please list in order who we should contact next

1. Name _____ Relation _____ Phone # _____

2. Name _____ Relation _____ Phone # _____

3. Name _____ Relation _____ Phone # _____

****

ALLERGIES:

Please list any **FOOD** allergies your child has: _____

_____

Please list any **NON FOOD** allergies your child has: _____

_____

Is your child allergic to any medications: _____ NO _____ YES if so, please explain

_____

_____

****

Child's Physician: _____

Phone Number: _____

Hospital Preferred: _____

Name of Insurance _____

Insurance Policy # _____

Policy Holder's Name: _____

I do hereby grant permission for the Wesley Circle of Friends Preschool staff to authorize any necessary emergency medical procedures and/or transportation for my child _____. I will be responsible for any medical expenses and for the care necessary for my child's recovery as prescribed by my own physician.

_____ _____

Parent/Guardian Signature Date

OTHER IMPORTANT INFORMATION

Names and ages of other children at home: _____

_____

Child's previous group involvement: _____

_____

Personal habits, behavior issues or other parental concerns: _____

_____

Physical limitations or special needs: _____

_____

What are your child's interests? Other activities? _____

_____

Is your child potty trained? _____ no _____yes

(Three year olds and four year olds MUST be potty trained.)

****

Are you a member of Wesley Church? _____ no _____ yes

Are you a member of another church? _____ no _____ yes

If yes, name of church _____

If no, would you like to know more about the life of Wesely Church? _____no _____yes

****

Parents' Occupations _____

_____

Are there any hobbies or talents you would like to share with the children at WCOF

_____ no _____ yes

How did you hear about WCOF Preschool? _____

_____