CARMEL UMC preschool

Office Use Only
Date _____
Check #_____
Total_____
Program Fee_____
May 2025_____

2024-2025 Preschool Registration Form

Child's Last Name:_____ **First Name:** _____

Circle One: Male/Female **Birth** Month/Day/Year: ___/___/_____

Address: _____

City:_____Zip:_____

Primary Contact:_____

Relationship to Child:_____

Cell #: _____ **Cell phone service provider (AT&T, Verizon, etc):**_____

EMail:_____

Additional Contact:_____

Relationship to Child:_____

Cell #: _____ **Cell phone service provider (AT&T, Verizon, etc.):**_____

EMail:_____

Bunnies: 18 Months before 9-1-2024

$185 Program Fee (One time fee. Due at registration)
$250 Monthly Tuition

____ **Mon/Wed**
____ **Tue/Thurs**

Please indicate first and second choice.

Ducks: 2 years before 9-1-2024

$210 Program Fee (One time fee. Due at registration)
$310 Monthly Tuition

____ **Mon/Tues/Wed**
____ **Tues/Wed/Thurs**

Please indicate first and second choice.

Threes: 3 years before 9-1-2024

$210 Program Fee (One time fee. Due at registration)
$310 Monthly Tuition

____ **Mon/Tues/Wed**
____ **Tues/Wed/Thurs**

Please indicate first and second choice.

Fours (Pre-K): 4 years before 9-1-2024

$235 Program Fee (One time fee. Due at registration)
$380 Monthly Tuition

____ **Mon/Tues/Wed/Thurs**

Alt. K: 5 years before 9-1-2024

$235 Program Fee (One time fee. Due at registration)
$380 Monthly Tuition

_____ **Mon/Tues/Wed/Thurs**

Financial and Enrollment Agreement for 2024-2025

Please initial each section listed, then sign and date at the bottom.

_____I have received a copy of the Carmel United Methodist Church Preschool Parent Handbook and agree to the preschool's financial policy including but not limited to registration, tuition/programming fee, withdrawal and late fees. ALL FEES/TUITION DEPOSITS COLLECTED ARE NONREFUNDABLE

_____I have received a copy of the Carmel United Methodist Church Parent Handbook and agree to the preschool's policy regarding illnesses and medical/health records.

- **I will provide a vaccination record for my students before school starts (new students) or within 30 days of their next birthday (returning students).**

_____I have received a copy of the Carmel United Methodist Church Preschool 2024-25 Student Calendar and understand that I will not receive financial credit for any missed school days, vacations, or school closures.

_____ I understand that requests for teachers will not be accepted, as the teachers and staff at Carmel UMC Preschool work together to make the very best environment for all students. I may make one friend request by listing their name here: _____. CUMC will do our best to honor this request IF the other family also requests your child.

This agreement has been read, and it is understood that this agreement is not subject to cancellation except by mutual agreement and by consent of Carmel United Methodist Church Preschool. This agreement also ensures that no special terms or privileges other than those mentioned herein have been promised.

_____ _____

Parent/Guardian Signature **Date**

Emergency Authorization 2024-2025

Indicate those to contact in case of an emergency

1.Name:_____ Phone:_____ Relationship:_____
2.Name:_____ Phone:_____ Relationship:_____
3.Name:_____ Phone:_____ Relationship:_____

I hereby give my permission for my child to attend and participate in activities sponsored by Carmel United Methodist Church (CUMC) during the 2023-2024 school year.

I hereby agree that CUMC and it agents, employees, consultants, affiliates and successors shall have no liability whatsoever for any injury or damage to my child or loss or damage to his/her personal property sustained while he/she is participating in the activity stated above or in any way connected with or arising out of the activity stated above.

I hereby release CUMC and its agents, employees, consultants, affiliates and successors for any and all claims demands, causes of action, liabilities, losses, damages, expenses, and costs that may arise from any and all injuries and damages sustained by my child or to any property of my child while engaged or in any way involved in the activity stated above.

I hereby authorize the person(s) named immediately above to authorize or secure such medical care, consultation and treatment (including the execution of necessary required medical authorization forms documents and statements) as may be necessary in case of an emergency. If I or the persons named immediately above am/are not available during an emergency, I authorize such medical care, consultations and treatments for my child as may be necessary. I understand that it is my responsibility and not that of CUMC to pay all costs and expenses incurred in connection with such care, consultation and treatment and I hereby agree to pay all such costs and expenses.

I hereby represent and certify that I am the parent or guardian of the above named child, and I have read, understand and do hereby voluntarily execute this authorization and release of liability.

_____ _____

Parent/Guardian Signature **Date**

Student Information 2024-2025 **Class:_____**(office use only)

The following information will be shared with your child's teachers:

Student's Name: _____

Name to be used in class:_____

1. **Is this your child's first experience at Preschool? Yes _____ No _____**

2. **If your child attended CUMC Preschool before, who were/are their teachers?**
   _____

3. **What is the primary language spoken in your home? _____**

4. **Is your child in any type of developmental program?** (Examples: Speech, Occupational therapy, etc..)
   Yes _____ No _____ If yes, please esplain:
   _____
   _____

5. **Please list any siblings and their ages: _____**
   _____
   If older siblings attended our preschool, who were their teachers and do you think a teacher with a similar style would benefit this student?_____
   _____

6. **What do you hope your child will learn at preschool this year?_____**
   _____
   _____

7. **How would you describe your child? _____**
   _____
   _____

8. **Is there anything else we should know about your child to make this the best year possible?**
   _____
   _____

9. **May we share your email address with other classmates for social communication (birthday parties, playdates, etc.? Yes _____ No_____**

10. **I give permission for photos to be taken of my child and published on the preschool's closed group app (Only those within the preschool app. will have access)? Yes _____ No_____**

Please Sign: _____

Carmel United Methodist Church Preschool
Tuition Authorization 2024-2025 School Year

Payment on Behalf: Child's/Children's First and Last Name

_____

(please print name/names)

(Please initial)

___ All Payments are paid by automatic withdrawal through the preschool's management software

(Please mark ONE of the following)

Payment Method

___ACH (direct deposit from bank account-No Fee)-This is the method of payment we will utilize for tuition payments.

OR

___Credit Card (Fee added 2.95%)-This is the method of payment we will utilize for tuition payments.

_____ _____

Parent/Guardian Signature **Date**

CARMEL UMC
preschool

Class:_____(office use)

Drivers Release

2024-2025 school Year

Child's Name:_____

Please list below everyone who will be allowed to pick up your child (include yourself, spouse, grandparents, aunts, friends, etc.)

Identification will be requested from any person on the list the first time they pick up as well as in last-minute situations.

Please call the office or make your teacher aware if a last minute situation arises.

NAME	RELATIONSHIP

1._____

2._____

3._____

4._____

5._____

6._____

7._____

List anyone NOT allowed to pick up:

Note any special circumstances here (i.e., non-custodial parent situations, etc.)

1._____

2._____

Parent Signature:_____ Date:_____

Food Allergies/Health Concerns 2024-2025

Child's Name_____

Does your child have a food allergy or any other health concern, which we need to be informed of?

NO____ (No other information is needed on these pages or the next, please sign and date.)

Parent Signature:_____ **Date:**_____

YES____My child has a medical condition that may require attention throughout the school day.

1. **What is the medical condition?**_____
2. **What additional care or attention needs to be taken for the health and safety of your child? (Medication, adaptation of day, action plan should they need additional care, etc.)**

   _____

   _____

   _____

A doctor's note with the diagnosis and plan of action must be provided to the preschool before 8-1-2024

Parent Signature:_____ **Date:**_____

YES____My child has a physician-diagnosed food allergy which requires an action plan and medication.

1. **Which food(s) is your child allergic to?**_____

2. **What does a reaction look like for your child if they have one?** _____

   _____

3. **If your child has a food allergy, do they require an EpiPen?**

   NO_____(Other children may have access to this food in the classroom.)

   YES_____(This food item(s) will be restricted for all students in the classroom. An allergy care plan, from a physician, must be in the office before 8-1-2024.

Parent Signature: _____ **Date:** _____

EpiPen/Benadryl Form 2024-2025

Please complete the following form for all diagnosed food allergies.

I/We give permission to the staff of the Carmel United Methodist Church Preschool program to administer an EpiPen or premeasured Benadryl to_____ due to an allergic reaction to _____.
(child's name)

I/We will provide a doctor-prescribed EpiPen/and/or premeasured Benadryl with prescription label attached to be kept in _____ classroom/backpack when he/she is in attendance.
(child's name)

I/We agree to come to the school after the EpiPen/Premeasured Benadryl has been administered, to check on _____.
(Child's name)

Symptom and Plan of Action

List the steps that need to be taken if your child has a reaction(ex: 1. Rash, Give Benadryl 2. Difficulty breathing give EpiPen / call guardian). 911 is always called when an EpiPen is given.

Symptom and Plan of Action

1._____

2. _____

3. _____

Before August 1, 2024, we MUST have the following:

- **A Doctor's signed care plan/plan of action**
- **All medication (EpiPen, Benadryl, etc…)**

This permission covers the school year August 2024 through May 2025

Parent/Guardian Signature: _____ Date: _____