

## CHILD ENROLLMENT FORM

**Childs Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Preferred Name (if different from above) \_\_\_\_\_

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

Zip Code \_\_\_\_\_

**Mothers Name:** \_\_\_\_\_

Address if different than above: \_\_\_\_\_ Cell #: \_\_\_\_\_

Employer: \_\_\_\_\_ Work #: \_\_\_\_\_

Email: \_\_\_\_\_

**Fathers Name:** \_\_\_\_\_

Address if different than above: \_\_\_\_\_ Cell # \_\_\_\_\_

Employer: \_\_\_\_\_ Work # \_\_\_\_\_

Email: \_\_\_\_\_

Please list at least 2 people to be contacted in the event of an emergency **if the parent cannot be contacted:**

1. Name: \_\_\_\_\_ Cell #: \_\_\_\_\_

Address: \_\_\_\_\_ Home #: \_\_\_\_\_

Relationship to the Child: \_\_\_\_\_ Work #: \_\_\_\_\_

2. Name: \_\_\_\_\_ Cell #: \_\_\_\_\_

Address: \_\_\_\_\_ Home #: \_\_\_\_\_

Relationship to the Child: \_\_\_\_\_ Work #: \_\_\_\_\_

**\*\*Please complete the other side of the form\*\***

## **Annual Class Roster**

Each year we prepare a roster for each group of children in our program. This roster will not be given to any persons other than parents of children enrolled in his/her class.

### **I authorize the following to be listed on the parent roster:**

Parents Name:	_____ Yes	_____ No
Address:	_____ Yes	_____ No
Home Number:	_____ Yes	_____ No
Cell Number:	_____ Yes	_____ No
Email:	_____ Yes	_____ No

### **Child Background:**

Ethnicity: Hispanic/Non-Hispanic (circle)

Race: White, Black, Hispanic, Asian, American Indian/Native American, Alaskan Native, Native Hawaiian, Pacific Islander, Multiracial, Not Specified (circle)

Chronic Physical Problems: \_\_\_\_\_

\_\_\_\_\_

History of Hospitalization: \_\_\_\_\_

Diseases the Child has had: \_\_\_\_\_

Allergies and Treatment: \_\_\_\_\_

\_\_\_\_\_

Medications, Food Supplements, Modified Diet or Fluoride Supplements: \_\_\_\_\_

\_\_\_\_\_

List of people to whom this child **CAN BE** released to:

\_\_\_\_\_

\_\_\_\_\_

List of people **NOT PERMITTED** to pick up this child:

\_\_\_\_\_

\_\_\_\_\_

Restraint papers or Divorce Decree: YES or NO

## CHILD MEDICAL STATEMENT

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

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Limitations or health condition (including allergies, medications, dietary restrictions)

### Immunizations: Please check one:

Complete for age: \_\_\_\_\_ Yes \_\_\_\_\_ No

In Process: \_\_\_\_\_ Yes \_\_\_\_\_ No

### Exempt from Immunizations: Please check one:

Religious conviction: \_\_\_\_\_ Yes \_\_\_\_\_ No

Health concern: \_\_\_\_\_ Yes \_\_\_\_\_ No

Other: \_\_\_\_\_

**This child has been examined and is in suitable condition to participate in group care.**

Signature of examining (check one)

\_\_\_\_\_ Physician \_\_\_\_\_ Physician's Assistant \_\_\_\_\_ Advanced Practice Nurse

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

Phone: \_\_\_\_\_ **DATE OF EXAM:** \_\_\_\_\_

### Assessments/Screenings Completed: Please check one

Vision: \_\_\_\_\_ Yes \_\_\_\_\_ No Date Completed: \_\_\_\_\_

Hearing: \_\_\_\_\_ Yes \_\_\_\_\_ No Date Completed: \_\_\_\_\_

Dental: \_\_\_\_\_ Yes \_\_\_\_\_ No Date Completed: \_\_\_\_\_

Lead: \_\_\_\_\_ Yes \_\_\_\_\_ No Date Completed: \_\_\_\_\_

Hemoglobin: \_\_\_\_\_ Yes \_\_\_\_\_ No Date Completed: \_\_\_\_\_

Reason not completed: (Check with applies) \_\_\_\_\_

# EMERGENCY MEDICAL AUTHORIZATION

(State of Ohio Revised Code Section 3313.712)

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

## PART I OR PART II MUST BE COMPLETED

### PART I: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Dentist \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Medical Specialist \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Local Hospital \_\_\_\_\_ Emergency Room Phone (\_\_\_\_) \_\_\_\_\_

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

\_\_\_\_\_  
\_\_\_\_\_

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

## DO NOT COMPLETE PART II IF YOU COMPLETED PART I

### PART II: REFUSAL TO CONSENT

I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

\_\_\_\_\_  
\_\_\_\_\_

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

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

## EMERGENCY CARD

School

Student's Name \_\_\_\_\_ Room \_\_\_\_\_

\_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Birthdate \_\_\_\_\_

Father/Guardian's Name \_\_\_\_\_

Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone/Pager \_\_\_\_\_

Place of Employment \_\_\_\_\_

Mother/Guardian's Name \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone/Pager \_\_\_\_\_

Place of Employment \_\_\_\_\_

In the event this student becomes ill at school but does not need medical attention, name three people, i.e., relative, neighbor, child care provider, to be contacted if you cannot be reached.

1. \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

2. \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

3. \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

## PARENT PERMISSION FORM

☐

I DO give permission for photos featuring my child to be used by St. Mary Preschool in print or electronically for advertising or marketing purposes, for any classroom school activities, ClassDojo, for school fundraising events, activities, or projects and/or on the school website and Facebook Page. I understand that St. Mary Preschool will not identify my child in photos using their address, phone number, or any description of their personal characteristics.

☐

I DO NOT give permission for photos featuring my child to be used by St. Mary Preschool in print or electronically for advertising or marketing purposes, for any classroom or school activities, ClassDojo. for school fundraising events, activities, or projects, and/or on the school website and Facebook Page.

☐

If NO to the above, I DO give permission for my child's photo to be taken and used for ONLY ClassDojo and the school yearbook.

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Signature of Legal Guardian

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Date

**\*\*Please see the preschool director for clarification or questions**

**Office Use Only:**

Date Received: \_\_\_\_\_

Cash/Check: \_\_\_\_\_

Amount: \_\_\_\_\_

**St. Mary Preschool Program  
2025-2026 Tuition Agreement**

**(\$75 NON-REFUNDABLE Registration Fee Per Child is Required at Time of Registration)**

**NAME OF CHILD TO BE ENROLLED IN ST. MARY PRESCHOOL**

\_\_\_\_\_ D.O. B: \_\_\_\_\_

Gender: Male/Female Ethnicity: Hispanic/Non-Hispanic Race: \_\_\_\_\_

In what public school district do you reside? \_\_\_\_\_

Fathers Name: \_\_\_\_\_ Mothers Name: \_\_\_\_\_

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

City/Zip: \_\_\_\_\_ City/Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Student resides with (circle): Mother/Father/Both/Other

Person responsible for tuition: \_\_\_\_\_

\_\_\_\_\_ We are a Parishioner of St. Mary – Lancaster

\_\_\_\_\_ We are a Parishioner of another Parish \_\_\_\_\_

\_\_\_\_\_ We are a non-participating Catholic or a member of another denomination

**CHECK THE CLASS (es) THAT YOU WANT TO ENROLL YOUR CHILD IN:**

\_\_\_\_\_ Clover 3 HALF days (Tuesday, Wednesday, Thursday) \_\_\_\_\_ AM Session 8:00am-11:00am

\_\_\_\_\_ PM Session 12:00pm-3:00pm

\_\_\_\_\_ PM Extended Day 3:00-4:00pm

\_\_\_\_\_ Clover 3 FULL days (Tuesday, Wednesday, Thursday) \_\_\_\_\_ 8:00am - 4:00pm

\_\_\_\_\_ Shamrock 5 HALF days (Monday – Friday) \_\_\_\_\_ AM Session 8:00am-11:00am

\_\_\_\_\_ PM Session 12:00pm-3:00pm

\_\_\_\_\_ PM Extended Day 3:00-4:00pm

\_\_\_\_\_ Shamrock 5 FULL days (Monday-Friday) \_\_\_\_\_ 8:00 am – 4:00 pm

**I have read the 2025-2026 tuition schedule and I agree to meet my tuition obligation according to the following payment plan.**

\_\_\_\_\_ **A.** Tuition paid in FULL by July 1, 2025 to receive a 3% discount.

Note: All preschool students in a family must be paid together in full to receive the 3% discount.

\_\_\_\_\_ **B. TEN EQUAL PAYMENTS due by the 15<sup>th</sup> of the month with the first payment due August 15<sup>th</sup> 2025 and the final payment by May 15<sup>th</sup> 2026.**

**\* A \$30 charge is assessed for a returned check.**

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



# St. Mary Preschool

## 2025-2026 Tuition Rates

### PRESCHOOL CLOVERS

3 Half Days	8:00 am – 11:00 am	Tuesday – Thursday	\$1,800
3 Full Days	8:00 am – 4:00 pm	Tuesday – Thursday	\$3,900

### PRESCHOOL SHAMROCKS

5 Half Days	8:00 am -11:00 am OR 12:00 pm-3:00 pm	Monday – Friday	\$2,500
	<i>5 Extended days from 3:00 pm-4:00 pm</i>	<i>Monday – Friday</i>	<i>Additional \$1,200</i>
	<i>3 Extended days from 3:00 pm- 4:00 pm</i>	<i>Tuesday - Thursday</i>	<i>Additional \$1,000</i>
5 Full Days	8:00 am – 4:00 pm	Monday – Friday	\$5,600

Families that have two or more children registered in the St. Mary Preschool will pay the full amount rate for their oldest child, and receive a 2% discount rate off the tuition rate for each additional child registered in the Preschool program.

## Preschool Tuition Payments and Policies

**All Preschool tuition payments must be made separately from a K-8 tuition payments. There is a \$75.00 non-refundable registration fee due for each child enrolling.**

Preschool tuition payments may be made in the following manner:

Full Payment: 3% discount off your tuition. Tuition must be paid in full for all students by July 1<sup>st</sup>, 2025.

### OR

Monthly Payments: 10 equal payments. Payments due the 15<sup>th</sup> of each month August – May.

**\*\* A \$10.00 late fee will be charged for each late payment.**