Which class are you registering for? _____

Child's Name: _____ Birth Date: __/___/___ M/F

Address: _____ Home Phone: _____

_____ Cell Phone: _____

Email address to receive school information: _____

Mother's Name: _____ Occupation: _____

Business Address:_____ Business Phone: _____

Father's Name: _____ Occupation: _____

Business Address:_____ Business Phone: _____

Siblings: _____ Age: ____ Where did you hear about us? (List one)

_____ Age: ____ Ad (List Publication) _____

_____ Age: ____ Referral _____ Other: _____

Has your child been in a pre-school before? _____ If yes, where? _____

Is anyone in your household an alumni? Who and when did they attend? _____

Please provide two **emergency contacts** if parents cannot be reached (as local as possible)

Name: _____ Name: _____

Relationship to child: _____ Relationship to child: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Medical Information

Child's Doctor: _____ Phone: _____

Allergies: _____

Please explain severity:_____

(We reserve the right to ask MD's confirmation of chronic allergy symptoms)

I hereby give permission for my child to receive medical care at school.

Parent's signature: _____ Date: _____

*****This form must be accompanied by a non-refundable registration fee of $150. Please make check or money order payable to: *The Glen Rock Cooperative Nursery School.***