THE PLACE FOR KIDS
UNITED METHODIST TEMPLE PRESCHOOL

201 Templeview Drive
BECKLEY, WV 25801
(304) 252-6213

2022-2023 Preschool Enrollment Application

I hereby make application to enroll my child _____
(Name child is usually called) in The Place for Kids/United Methodist Temple Preschool.

Child's Full Name: _____
Date of Birth: _____ Age: _____ Phone: _____
Address: _____

Father/Guardian Name: _____
Address: _____
Home Telephone: _____ Work Telephone: _____
Employer: _____ Occupation: _____

Mother/Guardian Name: _____
Address: _____
Home Telephone: _____ Work Telephone: _____
Employer: _____ Occupation: _____

Family Physician: _____
Address: _____ Office Phone: _____

IN CASE OF AN EMERGENCY, AND THE PARENT/GUARDIAN CANNOT BE REACHED CONTACT:

Name: _____
Address: _____
Telephone: _____ Relative: _____ Friend: _____
Take my child to (Name of Hospital): _____

LIST ALLERGIES: _____

Circle the appropriate response: *DROP OFF: 8:30A.M. CLASSES START: 9:00A.M.-12:00. P.M.

A. Five Days (Mon. -Fri.)	Monthly Tuition: $230.00
B. Four Days (Mon.-Thurs. or Tue. – Fri.)	Monthly Tuition: $215.00
B. Three Days (Mon. Wed. Fri. or Tues. Wed. Thurs.)	Monthly Tuition: $200.00

If your child attends Preschool and The Place for Kids Daycare, the additional cost for daycare will be:
3 Days- $80.00 Weekly 4 Days- $100.00 Weekly 5 Days- $125.00 Weekly

Application Fee: $40.00 Due when application is made.
Application fee does not apply if enrolled in daycare first

A BEKA BOOK FEE: $40.00 (2-YEAR-OLD) DUE WHEN APPLICATION IS MADE
A BEKA BOOK FEE: $50.00 (3-YEAR-OLD) DUE WHEN APPLICATION IS MADE
A BEKA BOOK FEE: $60.00 (4-YEAR-OLD) DUE WHEN APPLICATION IS MADE

Tuition is payable to * **UMT Preschool*** on the first school day of each month.

SIGNED: _____ DATE: _____

UNITED METHODIST TEMPLE
THE PLACE FOR KIDS
GENERAL INFORMATION FORM

CHILD'S NAME: _____

Name Child is usually called: _____

Who else lives in your home? (Please give names and ages of brothers and sisters). _____

_____

Give names and kinds of animal's child has for pets: _____

_____

What other information will help us to know and understand your child? _____

_____

Is there a certain way you calm your child if he/she is upset? _____

_____

Are there any fears we should be aware of? If so, please describe reaction. _____

_____

Has your child ever attended daycare or preschool before, or had opportunities to play with other children? _____

It helps us to know if you are expecting a new baby and what the child has been told; to know what an adopted child has been told about adoption; about recent experiences with death, separation, and other important happenings. This helps us to better understand your child's feelings, be able to respond to the child's questions, and to support the family situation. _____

_____

_____

Sleeping:	Own Room _____	Shared Room _____	With Whom? _____
	Time to Rise _____	Time to Bed _____	Nap? _____
Toileting:	Terms Used _____	Daytime Control _____	Nighttime Control _____

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Student Release Form

Child's Full Name: _____

Name Child goes by: _____

Mother's Name: _____ Phone Number: _____

Address: _____

Father's Name: _____ Phone Number: _____

Address: _____

Emergency Contact: _____ Phone Number: _____

Address: _____

Emergency Contact: _____ Phone Number: _____

Address: _____

*List four (4) people that **ARE AUTHORIZED** to pick up your child:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

*Please list any person(s) who are specifically **NOT** to pick up your child:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The first time your child is picked up by an authorized person, we will check the driver's license of the adult to verify their identity. If they are NOT listed above as an authorized person, your child will NOT be released to them. If you want a person to pick up your child who is NOT on this list, you must send a written notice. If there is any question the Director or employees in charge will call the parent to verify. This procedure is ***STRICTLY*** enforced.

I understand the rules for picking up children from The Place for Kids.

Parent/Guardian Signature _____ Date _____

UNITED METHODIST TEMPLE
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EMERGENCY MEDICAL AUTHORIZATION FORM

I, _____, of _____
(Parent/Guardian) (name of Child)

do hereby give my permission and/or consent for United Methodist Temple to secure and authorize such emergency medical care and/or treatment as my child, name above, might require while under the supervision of the said church. I also agree to pay all the costs and fees contingent on any emergency medical care and/or treatment for my child as secured or authorized under this consent.

PHYSICIAN TO CONTACT: _____ PHONE: _____

HOSPITAL PREFERENCE: _____

IN CASE OF EMERGENCY, WHO MAY BE CALLED IF PARENTS CAN NOT BE REACHED?
(Local Residents Only)

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____

DOES YOUR CHILD HAVE ANY HEALTH PROBLEMS WE NEED TO KNOW?

Diabetes _____ Seizures _____ Emotional Problems _____

Defects in sight _____ Hearing _____ Speech _____

Allergies to Medicine _____

Other _____

IS YOUR CHILD ON ANY MEDICATION AT THIS TIME? Yes _____ No ____

Please explain: _____

SIGNED: _____ DATE: _____

UNITED METHODIST TEMPLE
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PICTURE AND VIDEO PERMISSION FORM

I, _____, **DO** give my permission for United Methodist
Parent/Guardian Name

Temple, Daycare and/or Preschool, to take and/or display pictures or videos of my child,

_____, for use in the following ways:
Child's Name

___ bulletin board or other school displays

___ craft purposes

___ web page

___newspaper

___television

___video

___ audio

___special events

___social media

Signed: _____ Date: _____

CHILD HEALTH APPRAISAL

United Methodist Temple

DATE OF EXAM

The Place For Kids

Daycare **Preschool** School's Out / Summer Camp

CHILD'S NAME (Last, First, M.I.)	BIRTHDATE
CHILD'S ADDRESS (City/State/Zip)	TELEPHONE NUMBER

1. REVIEW OF HEALTH HISTORY

2. MEDICAL INFORMATION PERTINENT TO DIAGNOSIS AND TREATMENT IN CASE OF EMERGENCY.

3. SPECIAL INSTRUCTIONS TO PROVIDER REGARDING ANY MEDICATION REQUIRED DURING DAY CARE HOURS.

4. RECOMMENDED MODIFICATIONS OF LIMITATIONS OF CHILD'S ACTIVITIES OR DIET (i.e. allergies, etc.)

5. VISION
   ☐ Normal ☐ Abnormal

6. HEARING (auditory or equivalent)
   Subjective Screening (date)_____
   Audiometry (date) _____

7. MEDICAL

	NORMAL	ABNORMAL		NORMAL	ABNORMAL
Abdomen			Genitalia; Breasts		
Cardiovascular			Lungs		
Ears, Nose			Mouth, Throat		
Eyes			Skin, Lymph Nodes		
Extremities, Joints			Spine		

8. HGB
   ☐ Normal ☐ Abnormal

9. GM or HCT %
   ☐ Normal ☐ Abnormal

10. BLOOD PRESSURE
    ☐ Normal ☐ Abnormal

11. GROWTH MEASUREMENT

Height _____ Percentile _____ Weight _____ lbs. Percentile _____

12. DEVELOPMENTAL APPRAISAL

IS THE CHILD PROGRESSING NORMALLY WITH AGE OR GROUP? ☐ Yes ☐ No

NAME & ADDRESS OF PHYSICIAN

_____
Physician's Signature

_____
Date