



Enrolled Class

School Year

Enrollment Agreement

Student Information			
First Name:	Last Name:	Date of Birth:	Gender: <input type="radio"/> Male <input type="radio"/> Female
Address:		City/State/Zip Code:	Has your child attended school/daycare before here: <input type="radio"/> Y <input type="radio"/> N
Please list the previous child day care programs/schools your child has attended (names/dates):			
Does your child have any special needs or IEP? <input type="radio"/> Y <input type="radio"/> N (developmental, physical, emotional or learning)?	If marked yes, please describe below:		
Does your child have a resource teacher or specialist? <input type="radio"/> Y <input type="radio"/> N	Agency Name _____ Employee Name _____ Agency Name _____ Employee Name _____		
Will your child attend this center and another School/Program? <input type="radio"/> Y <input type="radio"/> N	If marked yes, list the school program describe below	I would like to enroll my child in music with the pastor? Once a month <input type="radio"/> Y <input type="radio"/> N	

Parent/Guardian Information #1			
11. First Name:	12. Last Name:	13. Relationship to child	13a. Custodial Agreement <small style="color: red;">If yes, please submit court orders to the office.</small> <input type="radio"/> Y <input type="radio"/> N
14. Address:		15. City/State/Zip Code:	16. Home Phone:
17. Cell Phone:	18. Work Phone:	19. Email	
20. Place of Employment and employment address		20. I authorize OBP to send school related emails to the email provided. <input type="radio"/> Y <input type="radio"/> N	

Parent/Guardian Information #2

First Name:	Last Name:	Relationship to child	Custodial Agreement If yes, please submit court orders to the office. <input type="radio"/> Y <input type="radio"/> N
Address:		City/State/Zip Code:	Home Phone:
Cell Phone:	Work Phone:	Email:	
Place of employment and employment address		I authorize SSLA to send school related emails to the email provided. <input type="radio"/> Y <input type="radio"/> N	

Emergency Contacts (Office personnel must be notified if an emergency contact is picking up your child)
 (Contacts must be someone other than parent/guardian and must be no more than 30 miles of the school)

Name	Relationship	Address	Primary Phone	Secondary Phone
Contact 1				
Contact 2				
Contact 3				

24. Persons **not** authorized to pick up child:

Medical Information

Physician Name:	Physician Phone:	Dentist Name:	Dentist Phone:
Allergies <input type="radio"/> Y <input type="radio"/> N Medical Conditions <input type="radio"/> Y <input type="radio"/> N Intolerances to food <input type="radio"/> Y <input type="radio"/> N	Please list any allergies, food intolerances or medical conditions here:		
Does your child have a epi-pen? <input type="radio"/> Y <input type="radio"/> N			
Health Insurance Provider:	Policy Number:		

Enrollment Preference

Please list your first, second and third choice below.

Enrollment is determined by random drawing, birth dates, demographics and parent preferences.

2 Year Olds (by June 1 st)	3 Year Olds	4/5 Year Olds
_____ Mon, Wed 9am-12pm	_____ Mon, Wed, Fri 9am-12pm	_____ Mon-Fri 9am-12pm
_____ Tue, Thur 9am-12pm	_____ Tue Thur 9am-12pm	_____ Mon-Thur 9am-12pm
	_____ Tue, Wed, Thur 12:30pm-3:15pm	_____ Mon-Thur 12:30pm-3:15pm

Additional Info

How did you hear about Old Bridge UMC Preschool?

I am a:

____ Returning Family/Sibling

____ OBUMC Member

____ New Family

____ Returning Family/Non S

MAT Services

Old Bridge UMC Preschool can administer prescription and non-prescription medications at our school. All forms must be fully filled out and medication must be checked in by a staff member trained to do so.

Only preschool staff members who have successfully completed the MAT training will administer medications in accordance with the physician’s or other prescriber’s instructions and in accordance with the standards of practice in the MAT training. All individuals listed to administer medication must have a valid Medication Administration Training (MAT) certificate, CPR, and first aid certificates covering all the children’s age levels at our school.

The approved medication administrators are approved to administer prescription medications using the follow routes: topical, oral, inhaled, eye, and ear, medication patches and epinephrine using an auto-injector device. We understand that if a child requires prescription medication to be administered rectally, vaginally, by injection or by another route not listed above, We will follow the procedures outlined in the MAT training for children with special health care needs.

A current list of trained staff members is kept updated on the preschool bulletin board. Usually, all lead teachers and the director will be trained. Documentation of MAT, CPR, and first aid certificates will be kept on site and available upon request to be seen.

Please sign below even if your child does not need medication at school. This is just a notice that you are aware that we can administer medications if needed.

Parent/Guardian Signature: _____ Date: _____

Please attach \$100 check for enrollment fee to the enrollment form (\$50 for each additional sibling). The enrollment fee will be returned if we are not able to enroll your child, however, it is non-refundable if parent chooses to withdraw child.

Orientation Meeting Agenda

Please do not sign until after you have attended your orientation meeting.

Orientation Date: _____

Orientation Time: _____

- _____ Hours of Operation
- _____ Tuition Agreement/ Tuition
- _____ Incident/Accident Policies
- _____ Inclusion
- _____ Licensing
- _____ Curriculum/Guidance & Discipline
- _____ Playground
- _____ Enrichment Courses
- _____ Safety/Security
- _____ Evacuation Plans/Drills
- _____ Food/Nutrition
- _____ Allergies/Plans/Illness
- _____ Medication
- _____ Communication/Parent Portal
- _____ Parent Questions

Signature of Parent/Guardian: _____ Date: _____

Facilitator Name/Position: _____ Date: _____