

THORNDALE Learning CENTER



REGISTRATION 2020-2021

Child's Name _____ Name to be used in School _____

First Middle Last

Date of Birth _____ Gender _____

Address _____

Street City Zip Code

Home Phone Number _____

Father's Name _____ Employer _____

Address (If different) _____ Work Phone # _____

Cell Phone # _____

Email _____ May we Share with the Class _____

Mother's Name _____ Employer _____

Address (If Different) _____ Work Phone # _____

Cell Phone # _____

Email _____ May we Share with the Class _____

Please Check Program Desired:

_____ Three's Class: Tuesday, Wednesday, Thursday - \$200 Per Month

_____ Four's Class: Monday, Wednesday, Friday - \$200 Per Month

_____ PreK Class: Monday, Tuesday, Wednesday, Friday - \$250 Per Month

(Four & Fives Years Attending Kindergarten in the next Fall)

_____ Four and PreK Enrichment: Thursday - \$ 50 Per Month

_____ Kindergarten: Mon.-Fri. 9:00-3:00 -\$470 Per Month

I understand that tuition is due at the first of each month. A late fee of \$25 will be applied to all payments made after the 15th of each month. Tuition is paid one month in advance and is non-refundable without a 30 written notice of withdraw from the school.

Please include the \$60.00 Non-Refundable Registration fee along with the Registration form to reserve the child's space. An Activity fee, not to exceed \$45.00, will be due by August 1.

Parent's Signature Date

Parent's Signature Date

Director's Signature Date

Date Rec'd Amount Check #

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STUDENT INFORMATION

Student Name _____ Name To Be Used in School _____

Address _____ Phone _____

Street

City

Zip

Date of Birth _____ Gender _____

Parent Emails _____

Members of the Household: Name Relationship Age

Pets: _____

School District _____ Township _____

How Did You Hear About Us? _____

Previous School Experience

This school _____ Other _____

Favorite Things To Do/Play _____

Any concerns or fears we should be aware of? _____

Any health concerns or allergies? _____

Any dietary restrictions? Please state the restriction and reason. _____



MEDICAL INFORMATION

Student Name _____ Date of Birth _____ Gender _____

Home Phone _____ Mom's Cell _____ Dad's Cell _____

Emergency Contact Other Than Parents

Name _____ Phone # _____

Relationship to Child _____ Cell # _____

Name _____ Phone # _____

Relationship to Child _____ Cell # _____

Persons Authorized to Pick Up Child: _____

Persons NOT Authorized to Pick Up Child: _____

If we are unable to contact any the above contacts, do we have your permission to have your child treated in case of an emergency? _____

Primary Physician _____

Physician's Phone _____

Dentist _____

Dentist Phone _____

Hospital Preference _____

Allergies _____

Dietary Restrictions and Reason _____

Medical Conditions _____

Current Medications _____

Any Condition that limits participation in certain activities _____

PLEASE ATTACH A COPY OF YOUR CHILD'S CURRENT IMMUNIZATION RECORD
