

Immanuel Lutheran School

2018-19 Registration



Date Registration Submitted: _____

A Complete Registration Packet Includes:

- | | |
|--|--------------------------------------|
| _____ Registration Form | _____ Birth Certificate |
| _____ Registration Fee (non-refundable)
<i>Payable to ILS</i> | _____ SC Certificate of Immunization |

Please note, a child may not begin school without a complete registration.

Office Use Only
 Check # _____ Amount: _____ Date Received: _____ Class: _____
 Registration, Activities & Supplies Fees due at time of registration:
 \$160 Returning Student \$210 New Student

Child's Full Name _____

Name child goes by _____ Date of Birth _____ Sex _____

Child's home address _____

City _____ ZIP _____ Phone _____

Subdivision/Community, if any _____

Father's Name _____

Mother's Name _____

Father's Employment _____ Phone# _____ Cell# _____

Mother's Employment _____ Phone# _____ Cell# _____

Email Address _____

Siblings' Names and Ages _____

Please check class/es you wish to enroll your child for the 2018-19 school year.

- | | | | |
|---|---|--|-------------------------------------|
| K1 (1-5 Days) 9:00-12:00
<u>No Lunch Option for K1</u> | () Mon () Wed () Fri
() Tues () Thurs | () K3 Tues/Thurs
() K3 Mon/Wed/Fri
() K3 Five Days, Mon-Fri | 9:00-1:00
9:00-1:00
9:00-1:00 |
| () K2 Monday/Wednesday | 9:00-1:00 | () K4 Tues/Thurs | 9:00-1:00 |
| () K2 Tuesday/Thursday | 9:00-1:00 | () K4 Mon/Wed/Fri | 9:00-1:00 |
| () K2 Friday -- Add On Day | 9:00-1:00 | () K4 Five Days, Mon-Fri | 9:00-1:00 |
| | | () Half-Day Kindergarten | 8:30-1:00 |

Please fill out the reverse side of this form.

Church Denomination: _____

Church currently attends: _____ Is your child baptized? _____

Has your child previously attended preschool? _____ If so, where? _____

Do you have any special concerns about your child that you would like to discuss with the teacher?

How did you hear about our School? () Friends (who) _____ () Front Sign
() Advertisements (where _____) () Other _____

In the event of an emergency, if parents cannot be reached, please contact:

Name	Address	Phone	Relationship
1. _____	_____	_____	_____
2. _____	_____	_____	_____

List all allergies (food or other) and any special precautions or treatment indicated for these allergies.

List any medications currently being administered to the child. _____

List any chronic health problems and history of hospitalization. _____

Child's Physician or Clinic _____

Address _____ Phone _____

MEDICAL EMERGENCY AUTHORIZATION

In the event reasonable attempts to contact me at (Phone) _____ or the other parent _____ at (Phone) _____ has been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by (Preferred Physician) _____ or in the event the designated practitioner is not available, by another licensed physician, and the transfer of the child to _____ (Preferred Hospital), or any hospital reasonable accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians, concurring in the necessity for such surgery are obtained, prior to the performance of such surgery.

Date _____

Parent's Signature _____