

# A Child's First Steps Preschool

Contact: Terrie Gehlsen

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[childsfirststeps@gmail.com](mailto:childsfirststeps@gmail.com)

Web Site: [achildsfirstpreschool.com](http://achildsfirstpreschool.com)

Registration Fee: \$170.00

(NON REFUNDABLE)

FOR OFFICE USE ONLY

CLASS A.M. or P.M. \_\_\_\_\_

PAID REGISTRATION \_\_\_\_\_

TUITION \_\_\_\_\_

DATE REGISTRATION RECEIVED \_\_\_\_\_

Monthly/Class Tuition: (Circle One)

2's Class T/Th. \$215.00 a month

3's Class T/Thur. \$230.00 a month

4's Class M/W/F \$270.00 a month

4's **Extension Class** 5 Class Days \$330.00 a month

Please complete Front and Back of Form

Indicate Class Time Preferred:

a.m. (9:00-11:30)

p.m. (12:15-2:45)

Name of

Child \_\_\_\_\_

Last

First

Birthday \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Address \_\_\_\_\_

House/Apt. # Street

City

Zip

Name of Parent/Guardian \_\_\_\_\_ Employer \_\_\_\_\_

Wk Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_ Employer \_\_\_\_\_

Wk Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Person(s) authorized to pick your child up from school

1. \_\_\_\_\_ 2. \_\_\_\_\_

Name

Phone number

Name

Phone number

Emergency Contact Information

Name

Relationship

Phone number

## Medical Information

Name of Primary Physician\_\_\_\_\_ Phone Number\_\_\_\_\_

Completed Tetanus Series (DPT)? Yes No Date of Tetanus\_\_\_\_\_

Does the child have any chronic diseases? Yes No

If Yes, please list and explain \_\_\_\_\_

Does the child have any food and/or drug allergies? Yes No

If Yes, please list and explain \_\_\_\_\_

## Permission for Emergency Medical Treatment

I, \_\_\_\_\_ authorize A Child's First Steps to seek

Medical treatment for my child, \_\_\_\_\_, in the event of

an emergency and/or in the case a parent/guardian cannot be reached.

Siblings/Name(s) and their ages

Email\_\_\_\_\_

Signed\_\_\_\_\_ Date\_\_\_\_\_

Parent or Legal Guardian

Terrie Gehlsen - Cell 253-224-4828

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