

Registration Application 2018 – 2019

NEW LIFE COMMUNITY PRE-SCHOOL 380 Lakeland Avenue Sayville, NY 11782

Phone: (631) 589-8998

Fax: (631) 589-4533

Email: nlcps@nlcc-li.com

Three-School Program (child must be age 3 by December 1, 2018)

2 Days A.M. Choice of Days: _____ Tues. & Thurs. or Wed. & Fri. recommended.

3 Days A.M. Choice of Days: _____ Mon./Wed./Fri. recommended.

4 Days A.M. Choice of Days: _____

5 Days A.M.

Child's Name _____ Female Male

Does your child have a nickname? _____ If so would you prefer us to use their formal name or
nickname at school? _____ Nickname: _____

Address _____
(Number and street) (Town) (Zip)

Date of Birth _____ Home Telephone # _____

Mother's Name _____ Living? Yes No

Mother's Cell # _____ Mother's Work # _____

Mother's Email _____

Father's Name _____ Living? Yes No

Father's Cell # _____ Father's Work # _____

Father's Email _____

Guardian's Name (if applicable) _____

Child lives with: Both parents Mother Father Guardian

Name(s) and age(s) of brothers & sisters _____

Did any of the above attend New Life Community Pre-School? Yes No

Does your family have a home church? Yes No

If so, name of church: _____

Has your child previously attended a pre-school or daycare program? Yes No

If so, where? _____

Did your child have a positive experience? _____

Do you have any requests regarding your child's placement? Your requests will be taken into consideration, but we cannot guarantee that all requests can be accommodated.

Is there anything about your child you feel his/her teacher should know (sensitive to loud noise, needs help in the bathroom, doesn't like to get hands dirty, difficulty separating from parents, etc....)?

Does your child receive any early intervention services (speech, OT, PT)?

What are your child's favorite toys or activities (trains, dinosaurs, painting, dolls, sports)?

Do you have any concerns regarding your child's development?

Where did you learn about New Life Community Pre-School?

PLEASE LIST ANY FOOD ALLERGIES AND LEVEL OF SEVERITY:

PLEASE LIST ANY MEDICAL INFORMATION THAT WE SHOULD BE AWARE OF:

DISMISSAL RELEASE AUTHORIZATION for _____
(Child's Name)

Who do you authorize to pick up your child (other than the parents) at dismissal?

PLEASE NOTIFY US **IN WRITING** OF ANY CHANGES

Name _____ Relationship to Child _____ Phone _____

Name _____ Relationship to Child _____ Phone _____

Name _____ Relationship to Child _____ Phone _____

Name _____ Relationship to Child _____ Phone _____

Name _____ Relationship to Child _____ Phone _____

Name _____ Relationship to Child _____ Phone _____

EMERGENCY RELEASE:

I give permission that in case of an emergency; my child _____
may be taken to a hospital for medical treatment. (Child's Name)

Parent or Guardian Signature _____

Emergency contact name and telephone number in case you cannot be reached.
(PLEASE PROVIDE MORE THAN ONE, AND NOTIFY US OF ANY CHANGES.)

Name _____ Relationship to Child _____ Phone _____

Name _____ Relationship to Child _____ Phone _____