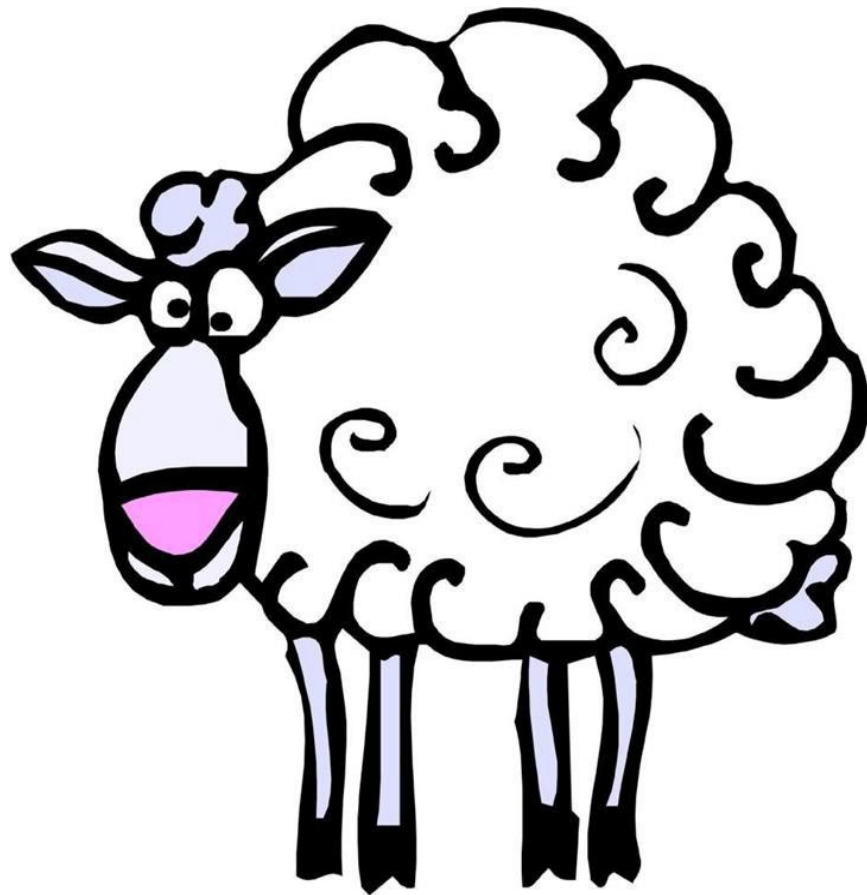


Shepherd's Flock Preschool

Enrollment Forms

2026-2027



Shepherd's Flock Preschool

A Ministry of Chesapeake Christian Fellowship
377 W Central Ave, Davidsonville MD 21035
410-798-1413

Shepherd's Flock Preschool 2026-2027 Updates

Tuition Rates

Part Time 8:30am – 12:00pm	Monthly Tuition	Registration Fee Non-Refundable	Before/Aftercare Must Pre-Register	Annual Snack Fee	Curriculum
2 Days Part Time	\$200	\$125	\$8.00 Per Hour	\$125	N/A
3 Days Part Time	\$300	\$125	\$8.00 Per Hour	\$125	N/A
4 Days Part Time	\$400	\$125	\$8.00 Per Hour	\$125	N/A
5 Days Part Time	\$500	\$125	\$8.00 Per Hour	\$125	N/A
Full Time 8:30am – 3:30pm	\$980	\$125	\$8.00 Per Hour	\$250	Pre-K Only \$150 - \$200

New School Hours

- 8:30am – 3:30pm

Before & Aftercare is pay-as-you-go

- Before Care Hours 7:00am – 8:15am
- After Care Hours 3:45pm – 5:00pm
- Parents must register for Before & After care

Important Dates

- Re-enrollment for 2026/2027 – February 2-16, 2026
- End of 2025/2026 School Year – June 5, 2026 (Half Day - Ends at 1:00pm)
- Start of 2026/2027 School Year – August 31, 2026
- Registration Fee is applied to the 1st month of tuition

Lions & Lambs Summer Program

- Open to Ages 2-4 & Grades K-7th
- June 15 – August 14 | 8:00am – 3:00pm
- \$250 Per Week | Before & After Care \$8 Per Hour

Shepherd's Flock Preschool Enrollment Form School Year 2026/2027

Please complete the following information regarding your child's enrollment for the upcoming school year. **A non-refundable \$125 registration fee is required for this form to be considered for enrollment.** The remaining paperwork must be submitted before the start of school. You will be notified via email of acceptance within two weeks.

If you have any questions call (410) 798-1413 or email SFdirector@4thelord.org

Student Name: _____ DOB: _____

Are you a returning student? Yes _____ No _____

Mark Full Days & Half Days Needed

Please take note you may be waitlisted for some timeslots

	Monday	Tuesday	Wednesday	Thursday	Friday
Half Day 8:30am – 12:00pm					
Full Day 8:30am – 3:30pm					

Mark Hours of Before / After Care Needed

\$8.00 Per Hour (Charged in 30min Increments)

	Monday Hours Needed	Tuesday Hours Needed	Wednesday Hours Needed	Thursday Hours Needed	Friday Hours Needed
Before Care 7:00am – 8:15pm					
After Care 3:45pm – 5:00pm					

Shepherd's Flock Preschool
School Year 2026/2027

Parent Name(s): _____ / _____

Parent Phone Number(s): _____ / _____

Parent Email(s): _____ / _____

Home Address: _____

Date Signed: _____

Miscellaneous Information

- If you have any questions (410) 798-1413 or email SFdirector@4thelord.org
- To reserve your enrollment position, you must submit this registration form along with a non-refundable \$125 registration fee and the appropriate paperwork.
- If, for any reason, your child will not be returning to Shepherd's Flock Preschool, please let us know immediately.

Parent / Guardian Signature: _____

Date: _____

For Staff Use Only:

Date of Registration: _____

Enrollment Form Complete: _____

Enrollment Fee Paid: _____

Operation Policy Signed & Dated By Parent: _____

Shepherd's Flock Preschool
New Student Registration Form

Only complete if your child is a new student

Our mission at Shepherd's Flock Preschool is to educate children in Biblical principles and academic standards. We strive to have our students prepared to enter grade school a step ahead and ready to take on any challenge they may face. Our activities are fun and structured to keep children engaged, and we provide incentives to reward positive behavior and academic accomplishments.

Parent Name(s): _____ / _____

Address: _____ / _____

Work Number: Mom: (_____) _____ / Dad: (_____) _____

Cell Number: Mom: (_____) _____ / Dad: (_____) _____

Primary Email: Mom: _____ / Dad: _____

Alternate Email: Mom: _____ / Dad: _____

Child's Full Name: _____

Child's D.O.B: _____ Child's Current Age: _____

Anticipated Schedule: _____

Membership Status at CCF: Member _____ Regular Attender: _____ Other _____

Introduce Your Child: _____

Detail Any Special Needs or Health Concerns: _____

What would you like to see your child accomplish in Shepherd's Flock?

Shepherd's Flock Preschool
Photograph & Video Release Form

I hereby give permission for images of my child and their likeness, **without name recognition**, to be used in any and all publications, including but not limited to Shepherd's Flock and Chesapeake Christian Fellowship's printed and digital publications.

I have read and accept the above:

Name of Parent / Guardian (Print): _____

Parent / Guardian Signature: _____

Date: _____

Child's Name: _____

Child's D.O.B: _____

Parent Contract

I _____, I have received a copy of the **Parent Handbook** for Shepherd's Flock.

I am also aware of the termination policy and policy for reporting child abuse.

I agree to abide by the policies and procedures set forth in the handbook.

By signing this contract, I acknowledge my receipt of the **Parent Handbook** and agree to follow the policies and procedures defined within the **Parent Handbook**.

Signature: _____

Date: _____

During an emergency, the following person(s) are responsible for:

Task	Person / Staff	Task	Person / Staff
Declaring emergency	Director / Pastor	Arranging transportation	Director / Pastor
Calling for assistance	All Staff	Carrying medication	All Staff
Contacting families	All Staff	Taking attendance after evacuation	All Staff
Decision to evacuate	Director / Pastor	Determine emergency is over	Director / Pastor
Contact emergency site	Director / Pastor	Conduct emergency drill	All Staff
Communicating EP plan to parents and staff	Director	Carry distracter supply kit	All Staff

Procedures for Notifying Parents

1. Email
2. Phone Call
3. Text

_____ has received the above emergency preparedness plan for **Shepherd's Flock** and understand that every effort will be made to follow the plans listed above. In the event of an emergency not outlined in this plan I will be notified as soon as possible regarding the location and status of my child.

Parent Signature: _____

Staff Signature: _____

Provider Signature: _____

Date: _____

Annual Review Date:	Annual Review Date:	Annual Review Date:	Annual Review Date:	Annual Review Date:
Initials:	Initials:	Initials:	Initials:	Initials:

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
 LAST FIRST MI
 SEX: MALE FEMALE BIRTHDATE _____/_____/_____
 COUNTY _____ SCHOOL _____ GRADE _____
 PARENT NAME _____ PHONE NO. _____
 OR
 GUARDIAN ADDRESS _____ CITY _____ ZIP _____

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	Varicella Disease Mo / Yr	COVID-19 Mo/Day/Yr
1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1		DOSE #1
2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2		DOSE #2
3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr	
4	DOSE #4	DOSE #4	DOSE #4	DOSE #4									
5	DOSE #5												

To the best of my knowledge, the vaccines listed above were administered as indicated.

Clinic / Office Name
Office Address/ Phone Number

1. _____
 Signature Title Date
 (Medical provider, local health department official, school official, or child care provider only)

2. _____
 Signature Title Date

3. _____
 Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: Permanent condition OR Temporary condition until _____/_____/_____
 Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ Date _____
 Medical Provider / LHD Official

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign ‘Record of Immunization’ section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella**.
2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.
3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).
4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.
5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

“A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:

- (1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
- (2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
- (3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine.”

Please refer to the “**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**” to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the “**Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs**” guideline chart are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

CAFCP Enrollment: Yes: ___ No: ___

Meals your child will receive while in care:

BK ___ LN ___ SU ___ AM Snk ___ PM Snk ___ Evng Snk ___

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:

- (1) Complete all items on this side of the form. Sign and date where indicated. Please mark "N/A" if an item is not applicable.
- (2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name _____ Birth Date _____
 Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

Child's Home Address _____
 Street/Apt. # City State Zip Code

Parent/Guardian Name(s)	Relationship	Contact Information		
		Email:	C:	W:
			H:	Employer:
		Email:	C:	W:
			H:	Employer:

Name of Person Authorized to Pick up Child (daily) _____
 Last First Relationship to Child

Address _____
 Street/Apt. # City State Zip Code

Any Changes/Additional Information _____

ANNUAL UPDATES

 (Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name _____ Telephone (H) _____ (W) _____
 Last First

Address _____
 Street/Apt. # City State Zip Code

2. Name _____ Telephone (H) _____ (W) _____
 Last First

Address _____
 Street/Apt. # City State Zip Code

3. Name _____ Telephone (H) _____ (W) _____
 Last First

Address _____
 Street/Apt. # City State Zip Code

Child's Physician or Source of Health Care _____ Telephone _____

Address _____
 Street/Apt. # City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____ Date _____

INSTRUCTIONS TO PARENT/GUARDIAN:

- (1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____ Date of Birth: _____

Medical Condition(s): _____

Medications currently being taken by your child: _____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: _____

(2) If signs/symptoms appear, do this: _____

(3) To prevent incidents: _____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

COMMENTS: _____

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

Name of Health Practitioner

Date

Signature of Health Practitioner

(_____) _____
Telephone Number