Lord of Life Preschool 2026-2027 Registration Form

To Register: Please return this form with a $90.00 registration fee, $25 each Additional sibling

Registration checks are not refundable

For office use: Reg Fee Pd:_____ Date:_____ Ck#:_____ $:_____ Email:_____

Today's Date: ____ /____ /____ Childs Full Name: _____

Name child goes by (if different): _____ Does your child have an IEP?_____504?_____

Birthdate: ____ /____ /____ Age as of Sept. 1, 2026 3____ 4____ 5____

Has your child completed Preschool Screening ___Yes __ Not Yet

Is your child independently toilet trained? ___ Yes __ Not Yet

Parent/Guardian Info:

Child's Primary address:_____

City:_____ State:_____ Zip code:_____ Home/Primary phone (_____)_____

Contact #1 Name:_____

Primary Daytime Phone: (___) _____

Email (please print clearly)_____@_____

Home address (if different than above) _____

Contact #2 Name:_____

Primary Daytime Phone: (___) _____

Email (please print clearly)_____@_____

Home address (if different than above) _____

Check session desired: all classes can be taken on own, or in addition to another

Class			Cost/month x 9
_____M / W	9:00 am-Noon	3 year old's	$185.00
_____M / W	9:00 am-Noon	3 & 4 year old's	$185.00
_____T / Th	9:00 am-Noon	3 & 4 year old's	$185.00
_____M / T / W / Th	9:00 am-Noon	3 & 4 year old's	$340.00
_____M / T / W / Th	9:00 am-1:30 pm	K-Prep	$430.00
_____M / T / W / Th	8:00 am -9:00 am	Before School Care	$65 2 days | $90 4 days (circle days desired)
_____M / T / W / Th	Noon-1:30 pm	Lunch Bunch	$70 2 days | $95 4 days (circle days desired)

Must be 3 years of age and potty trained to begin our program. Children accepted year round.
Classes may be canceled due to low enrollment.

Lord of Life Preschool 2026-2027
Preschool Individual Form

Child's Full name: _____

Please list previous experiences in which your child has been separated from their parents:

_____

_____

Child lives with (please circle): Both parents | Mom | Dad | Grandparent(s) | Other _____

Names and ages of siblings and other children at home:_____

_____

Any concerns or fears that your child has that you want their teachers to know about:

_____

_____

Any known allergies/medical conditions (A special medical form may be required to have detailed information on file): _____

_____

Special needs or interests that you want us to know about: _____

_____

_____

Any serious illness in the last year:_____

_____

Your expectations as a parent about preschool:_____

_____

What would you like your child to learn at preschool?_____

_____

Lord of Life Preschool 2026-2027
Payment Authorization Form

For Office Use Only	Student #:	Date:

Parent Information:

Last Name:_____ First Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Name of Student:_____

Effective Date of Authorization: _____ /_____ /_____

Type of Authorization:

_____ New Authorization _____ Change Payment Amount

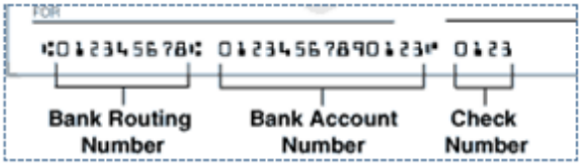
Date of monthly Payment (check one): _____1st of the month _____15th of the month 2 days = $185/month 4 days M/W & T/Th = 9 am-NOON $370/month K-Prep M-Th 9-1:30 pm = $430/month (9 monthly payments)	Before school: $65/2 days or $90/4 days Circle Days Desired M T W TH Total:_____ Lunch: $70/2 days or $95/4 days Circle Days Desired M T W TH Total:_____	**FOR OFFICE USE ONLY:** **Month of first withdrawal:_____** **Month of last withdrawal:_____** **Total each month:_____**

AGREEMENT : I authorize Lord of Life Church to process debit entries to my account according to the dates listed. I understand that written notice must be provided 15 days prior to the monthly withdrawal date in order to terminate authorization.

Authorized Signature _____ Date: _____

Please attach a VOIDED check here OR include your bank info below.

Please debit payments from my (check one):
_____Checking Account
_____Savings Account (contact your financial institution for routing #)



Routing Number:_____
Valid routing number must start with 0, 1, 2, or 3

Account Number:_____

Lord of Life Preschool 2026-2027 Permission Form

Student Name: _____

Handbook

I have received and read the Lord of Life Preschool Parent Handbook.

_____Yes

Photo Usage:

We frequently take photographs and videos to be used for preschool program videos, the Lord of Life website and Preschool Facebook page to give parents a sneak peek into our preschool days. We also may use photos for public purposes, including preschool promotion and publicity. When such photos are used, names of students are NEVER used.

_____ I give Lord of Life Preschool permission to use photographs of my child for internal and promotional use knowing that personal information of my child will NOT be used.

_____I **do not** give permission for my child's photos to be used by Lord of Life Preschool in any way. I realize that by checking this box my child will not be included in any preschool videos that may be created for the Christmas program and/or end of the year program and Graduation ceremony.

Change of clothes/bathroom assistance:

It is a requirement that all students are potty trained before entering preschool at Lord of Life, however we do understand that kids occasionally may have accidents. We require that students always keep a change of clothing in their backpacks in case of an accident. Please indicate by checking yes or no to the following permission statements: This will be retained and kept with student files.

_____Yes, I give Lord of Life Preschool staff permission to assist my child with a change of clothes after a bathroom accident. Staff may also assist my child with buttons/zippers as necessary.

_____No, I do not give Lord of Life Preschool staff permission to assist my child. I understand I will be called and must come care for my child within 20 minutes of receiving the call.

Date ____/____/____ Parent Signature _____

Immunization Form

Name_____ Birthdate_____

Enter the dates for each vaccine your child has received to date. Specify the month, day, and year of each dose such as 01/01/2010.

Immunizations required for child care, early childhood programs, and school.

Vaccine	Birth to 6 months			12 -24 months		At Kindergarten	At 7th grade	At 12th grade
Hepatitis B								
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)								
Haemophilus influenzae type b (Hib)								
Pneumococcal (PCV)								
Polio								
Measles, Mumps, Rubella (MMR)								
Chickenpox (varicella)								
Hepatitis A								
Tetanus, Diphtheria, Pertussis (Tdap)								
Meningococcal (MCV4)								

Minnesota law requires children enrolled in child care, early childhood education, or school to be immunized against certain diseases, unless the child is medically or non-medically exempt.

Instructions for parent or guardian:

1. Fill out the dates in chronological order even if your child received a vaccine outside of the age/grade category that the box is in. Depending on the age of your child, they may not have received all vaccines; some boxes will be blank.
   - If you have a copy of your child's immunization history, you can attach a copy of it instead of completing the front of this form.
   - Your doctor or clinic can provide a copy of your child's immunization history. If you are missing or need information about your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980 or 800-657-3970.
2. Sign or get the signatures needed for the back of this form.
   - Document medical and/or non-medical exemptions in section 1.
   - Verify history of chickenpox (varicella) disease in section 2.
   - Provide consent to share immunization information (optional) in section 3.

DEPARTMENT OF HEALTH
Immunization Program (2019)
www.health.state.mn.us/immunize

Are Your Kids Ready?

Child Care and Early Childhood Programs Immunization Law

Children are required to receive immunizations before enrolling in child care and early childhood programs in Minnesota or submit an exemption. This requirement applies to all licensed child care centers, family child cares, certified license exempt child cares, and early childhood programs such as preschool, school readiness plus, voluntary prekindergarten, and early childhood special education. Look for your child's age group in the chart below and see how many total doses of each vaccine are needed for their age.

Required Immunizations	3-4 months	5-6 months	7-15 months	16-23 months	24 months to kindergarten
Hepatitis B (Hep B)	2 Doses	2 Doses	3 Doses	3 Doses	3 Doses
Diphtheria, tetanus, and pertussis (DTaP)	1 Dose	2 Doses	3 Doses	3 Doses	4 Doses
Polio (IPV)	1 Dose	2 Doses	2 Doses	2 Doses	3 Doses
Pneumococcal (PCV)	1 Dose	2 Doses	3 Doses	3 Doses	
Haemophilus influenzae type b (Hib)	1 Dose	1 Dose	1 Dose	1 Dose	1 Dose
Measles, mumps, rubella (MMR)				1 Dose	1 Dose
Varicella (chickenpox)				1 Dose	1 Dose
Hepatitis A (Hep A)					1 Dose

Note: The number of doses may be different if your child is behind schedule. If your child has fallen behind on their vaccinations it is not too late to catch-up, talk to their health care provider.

Recommended but not required for child care or early childhood programs

Influenza (flu), COVID-19, respiratory syncytial virus (RSV), rotavirus and other vaccines are recommended for children to ensure they are fully protected. Talk to your health care provider about when your child should receive these immunizations.

Tips for parents and guardians

- Make sure your child has received all of the required immunizations before their first day of child care/early childhood program or submit an exemption.
- Submit a copy of your child's immunization record to their child care, early childhood program, or school. You can get a copy of their record from the clinic or find their record on Find My Immunization Record (www.health.state.mn.us/people/immunize/miic/records.html).
- Please complete the reverse side if your child requires an exemption for medical reasons or if you are opting for a non-medical exemption due to personal beliefs.

Vaccines for Infants, Children, and Adolescents (www.health.state.mn.us/people/immunize/basics/kids.html)

Contact Immunization Program at 651-201-5503 or 1-800-657-3970 for alternate format.
ID# 80154 (12/2024)

DEPARTMENT OF HEALTH

CHILD'S NAME (FIRST, LAST):_____ CHILD'S DATE OF BIRTH:_____

Medical and non-medical exemptions

Instructions for documenting medical or non-medical exemptions and history of chickenpox (varicella)

Follow steps 1 and 2 below to document a medical exemption, non-medical exemption, or history of chickenpox.

1. Place an X in the box to indicate a medical or non-medical exemption. If you are exempting your child from more than one vaccine, mark each vaccine you are exempting them from with an X.
2. Obtain signatures for exemptions or history of chickenpox disease.

Required Immunizations	Medical	Non-Medical
Hepatitis B (Hep B)		
Diphtheria, tetanus, and pertussis (DTaP)		
Polio (IPV)		
Pneumococcal (PCV)		
Haemophilus influenzae type b (Hib)		
Measles, mumps, rubella (MMR)		
Varicella (Chickenpox)		
Hepatitis A (Hep A)		

Medical exemption: A health care provider must review and sign a medical exemption. A health care provider includes a licensed physician, nurse practitioner, or physician assistant.
By my signature below, I confirm that this child should not receive the vaccines marked with an X in the table for medical reasons (contraindications) or because there is laboratory confirmation that they are already immune.

Signature: _____
(of health care practitioner)

Date:_____

Non-medical exemption: A parent/guardian must sign for a non-medical exemption and the form must be signed and stamped by a notary. A child is not required to have an immunization that is against their parent or guardian's beliefs. Choosing not to vaccinate may put the health of your child or others they are around at risk. Unvaccinated children who are exposed to a vaccine preventable disease may be required to stay home from school and other activities for up to 21 days to protect themselves and others.
By my signature I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs and I understand that they may be required to remain out of school and other activities for up to 21 days if exposed to a vaccine preventable disease.

Signature:_____Date:_____
(of parent/guardian)

Non-medical exemptions must also be signed and stamped by a notary:

Notary Stamp

This document was acknowledged before me on

_____ (date),

by _____
(name of parent or guardian)

Notary Signature:

_____

State of _____,
County of _____

History of chickenpox (varicella) disease: If a child has previously had chickenpox, they are not required to receive the varicella vaccine. A health provider must sign this form if the disease happened after Sept. 1, 2010. If the child had chickenpox before Sept. 1, 2010, a parent or guardian may sign this form.
My signature below means that I confirm this child does not need the varicella vaccine because they had chickenpox in the month and year _____
Signature:_____ Date:_____
(of health care practitioner, representative of a public clinic, or parent/ guardian)

Health Care Summary Form 2026-2027

MUST BE COMPLETED BY HEALTH CARE SOURCE

Child's Name:_____ Date of Birth:_____/_____/_____

Home Address:_____

_____ Phone #:_____

Parent(s) or Guardian(s):_____

Date of last physical exam?:_____

How long have you been seeing this child?:_____

How frequently do you see this child when he/she is **NOT** ill?:_____

Does this child have any allergies?:_____

Is a modified diet necessary?:_____

Is any condition present that might result in an emergency?:_____

What is the status of the child's:

Vision:_____

Hearing:_____

Speech:_____

Please list any important health concerns and if it requires special attention at school:

_____

_____

_____

Other information that could be helpful to the preschool staff:_____

_____

Signature of health source:_____ Date:_____/_____/_____

Address:_____

FAX COMPLETED COPY TO 763-427-1058

Preschool Emergency Contact & Allergy Alert Form 2026-2027

Child's Name:_____ Date of Birth:____/____/____

Home Address:_____

_____ Phone #:_____

1st Person to contact in case of emergency:

Name:_____ Phone #:_____

Relationship to Child:_____

2nd Person to contact in case of emergency:

Name:_____ Phone #:_____

Relationship to Child:_____

ANYONE NOT AUTHORIZED FOR PICK UP:_____

DOES THIS CHILD HAVE ANY KNOWN ALLERGIES?: YES/NO

IF YES, PLEASE LIST:_____

In accordance with state licensing requirements, the child's primary physician and dentist information must be filled in for this form to be considered complete.

Child's Primary Doctor:_____ Phone #:_____

Clinic Address:_____

Child's Primary Dentist:_____ Phone #:_____
(Family dentist is ok if child has never been seen.)

Dentist Address:_____

Preferred Hospital:_____

This form was completed by:_____ Date:____/____/____