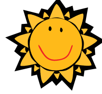
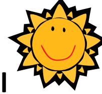

Trinity Preschool

515 S MacArthur Blvd. Springfield, IL 62704

"Sharing Christ-Meeting Needs"

Summer Camp Registration

Last Name___________________First Name___________________Middle Name______________

Birthday_________________ Sex F___M___ Is your child completely toilet trained? Yes/No

We are registering for ____Full Time (____days per week) Part Time_____(____days per week)

Mother's Name____________________________Father's Name__________________________

Family's Address____

Phone Number (c w h)____

Does your child have any medical conditions (allergies, etc) that the Learning Center should be aware of?____

Does your child have any diagnosed special educational needs (IEP, SMP, or 504)? ________________
____

- **Photo Agreement: I grant permission for my child to be included in any photos the center may use for school newsletters, yearbooks, web page, promotions, etc. (Names will not be used with pictures on the website).**
- **I have received and agree to the tuition policies and statement of fees of Trinity Learning Center.**
- **I/We give permission for Trinity Preschool to check with my child's current preschool/school regarding all the information included in this application. Trinity Preschool reserves the right to ask a parent to withdraw a student whose application was falsely completed or contains information that was misrepresented.**

_____________________________________ _______________

Signature of Parent/Guardian Date

Please submit:

Registation Fee ($20.00)

Health Record, Immunization Form, and Birth Certificate (______Please initial if already on file at Trinity)

Trinity Preschool
Student Information Sheet

Full Legal Name of Student__________________________________**Nickname**_________________

Father's Name:	Mother's Name:
Address:	Address:
City, State, Zip	City, State, Zip
Home Phone:	Home Phone:
Place of Employment:	Place of Employment:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
Email Address:	Email Address:

Adults to contact when parents/guardian cannot be reached:

Name of Adult	Phone Number
Relationship to Child:	

Name of Adult	Phone Number
Relationship to Child:	

Medical Contact:

Physician Name	Office Number
Dentist Name	Office Number

If the child has any of the following, please explain:

Medical Concerns:

Physical Challenges:

Allergies:

Does your child regularly take medicine? If so, what kind?

Restrictions for play?

ALL INFORMATION SHALL BE REGARDED AND HANDLED CONFIDENTIALLY.