

**STUDENT ENROLLMENT APPLICATION**  
**Ellettsville Christian Church**  
**Shining Stars Weekday Preschool**  
**731 Independence Street**  
**Ellettsville, IN 47429**

Student Name \_\_\_\_\_ Gender: Male Female

Name to use in Class \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Public School District \_\_\_\_\_

Church Membership (if any) \_\_\_\_\_

Previous Preschool (if any) \_\_\_\_\_

Name of Childcare Provider (if any) \_\_\_\_\_ Phone \_\_\_\_\_

**Please choose from the following class options:**

- |   |  |
|---|--|
| <input type="checkbox"/> 2-Day Class<br>Monday/Wednesday        | <input type="checkbox"/> 5-Day Class<br>Monday-Friday  |
| <input type="checkbox"/> 2-Day Class<br>Tuesday/Thursday        | <input type="checkbox"/> Optional Lunch Bunch 12:00-1:00<br>(A separate Enrollment Form will be mailed)<br>\$5 per day |
| <input type="checkbox"/> 3-Day Class<br>Monday/Wednesday/Friday |  |

All classes are 9:00-11:55. Children must be potty-trained. Requested class choice will be filled on a first come, first served basis.

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**To be completed by School Office:**

*Date Received* \_\_\_\_\_

*Registration Fee received:* \$ \_\_\_\_\_ *Date* \_\_\_\_\_ *Check #* \_\_\_\_\_

*Immunization Record*

*Supply/Curriculum Fee received* \$ \_\_\_\_\_ *Date* \_\_\_\_\_ *Check #* \_\_\_\_\_

*August Tuition received* \$ \_\_\_\_\_ *Date* \_\_\_\_\_ *Check #* \_\_\_\_\_

<b>Parent Information</b>	<b>Mother/Guardian</b>	<b>Father/Guardian</b>
Address (if different than child's)		
Home Phone		
Employer		
Work Phone		
Cell Phone		
E-mail—Work		
E-mail—Home		

Child lives with (circle)

*mother & father*      *mother only*      *father only*      *mother & stepfather*  
*father & stepmother*      *Grandparent*      *Guardian*

Please provide the following sibling information.

<b>Name</b>	<b>DOB</b>	<b>School</b>

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If your child is photographed during school activity, do you give your permission for your child's picture to be placed in the Ellettsville Journal or Herald-Times? \_\_\_\_\_ If your child is photographed with a group of children during school activities, do you give permission for your child's picture to be placed on the school web page/portfolios without a first or last name included? \_\_\_\_\_ If your child is videotaped during a school activity, do you give permission for the use of the video in school related functions? \_\_\_\_\_

I understand that Preschool Tuition is due monthly. Please initial. \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_

## RELEASE OF STUDENTS

To help us safeguard the children of Shining Stars Preschool, we are asking you to list those persons that will be allowed to pick up your child from preschool. If anyone other than you picks up the child, he/ she will be required to furnish identification before the student will be released into their care. The parent/guardian will be contacted by phone before a person not on the list may take the child. If the school is unable to contact you, the child will **NOT** be allowed to leave with this person. Please furnish the following information:

**IF UNABLE TO REACH PARENT/GUARDIAN, PLEASE CONTACT:**

*We must have two additional names, relationship and phone numbers.*

The following **MAY** pick up my child from school and may be called in case of emergency, illness or injury. Please include childcare provider.

<b>NAME</b>	<b>Relationship</b>	<b>Phone Number</b>

The following **MAY NEVER** pick up my child from school.

<b>NAME</b>	<b>Relationship</b>

Special Guardianship information should be listed below: (Legal documents must be on file in school office)

## Health Questionnaire

Has your child been diagnosed with any of the following:

ADD/ADHD	YES	NO
ALLERGIES	YES	NO
EPIPEN	YES	NO

Please list allergies: \_\_\_\_\_

ASTHMA	YES	NO
CHRONIC ILLNESS	YES	NO
DIABETES	YES	NO
HEART DISEASE	YES	NO
SEIZURES	YES	NO

Please specify: \_\_\_\_\_

Please list any surgeries/hospitalizations: \_\_\_\_\_

\_\_\_\_\_

Please list any medications and purpose: \_\_\_\_\_

\_\_\_\_\_

Has your child been tested for any special educational needs? If yes, describe and explain any educational impact:

\_\_\_\_\_

I give permission for appropriate information to be shared with other staff members as needed  
\_\_\_\_\_ YES \_\_\_\_\_ NO

*All information provided is for the strict use of the School Office and will be kept confidential unless otherwise specified*