



K-4 REGISTRATION FORM

Office Use Only	
\$275 NON-REFUNDABLE Registration fee	
Date Received:	_____
Registration Fee Received:	<input type="checkbox"/> Yes No
Amount Received:	Check #: _____
Amount Due:	_____
OPTIONAL FRIDAY:	Yes No
MALE OR FEMALE (circle)	
Notes:	_____

Child's Name: _____

Child's Birthdate: _____

Home Address: _____

Home Phone Number: _____

Email Address: _____

Mother's Name: _____ Mother's Cell Number: _____

Occupation: _____

Place of Employment: _____

Phone Number: _____

Father's Name: _____ Father's Cell Number: _____

Occupation: _____

Place of Employment: _____

Phone Number: _____

Child's Physician: _____ Phone Number of Physician: _____

Any known allergies? _____

Has your child ever had a fever-induced seizure? If so, please explain. _____

Relative or close friend in case of emergency: _____ Phone Number: _____

Please list any information or special instructions that you feel would be helpful to us regarding your child:

**A \$275 NON-REFUNDABLE registration fee must accompany this form to secure a spot for your child.
An updated immunization form must be presented by the first day of school.**