

# Community Alliance Church Preschool Information

*Welcome to Preschool!*

Community Alliance Preschool offers a caring Christian learning environment for children ages 3-5. The flexible daily routine offers children the opportunity to explore and problem-solve as they grow socially, physically, and academically. Daily lessons and activities incorporate math, literacy & language development, creativity, science, music and sensory exploration. The classroom environment is designed specifically to encourage hands-on learning as children prepare for success in kindergarten.

Classes will run September through May, following the Detroit Lakes Public School Calendar. Tuition is to be paid by the 5th of each month.

We welcome visitors! Feel free to call for more information or to set up a time to visit!

**PLEASE SUBMIT THE FOLLOWING TO COMPLETE ENROLLMENT:**

- \_\_\_\_\_ Admission Form
- \_\_\_\_\_ Non-refundable Registration Fee
- \_\_\_\_\_ Immunization Record
- \_\_\_\_\_ Health Care Summary
- \_\_\_\_\_ Medical Information Form

408 Elm Street West  
Detroit Lakes, MN 56501  
218.847.2266 Fax 218.847.3011  
[www.cacdl.com/preschool.html](http://www.cacdl.com/preschool.html)



# Preschool Registration

Must be 3 by 9/1/2021

Student's name \_\_\_\_\_

Date of birth \_\_\_\_\_

## Preschool class

\_\_\_\_\_ M-W-F 8:30-11:30

Cost \$175/month

Registration Fee \$35

LUNCH BUNCH!!! Bring a sack lunch and stay till 1:00. (*optional*)

\_\_\_\_\_ Option #1— Monday and Wednesday Cost \$55/month

\_\_\_\_\_ Option #2— Monday only Cost \$30/month

\_\_\_\_\_ Option #3— Wednesday only Cost \$30/month

# 2021-22 Community Alliance Preschool Admission Form

Child's name \_\_\_\_\_ Nickname \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Birth date \_\_\_\_\_ Sex: Male Female

Father's name \_\_\_\_\_ Mother's name \_\_\_\_\_

Home phone # (Father) \_\_\_\_\_ (Mother) \_\_\_\_\_

Cell phone # (Father) \_\_\_\_\_ (Mother) \_\_\_\_\_

Work phone # (Father) \_\_\_\_\_ (Mother) \_\_\_\_\_

Email address: \_\_\_\_\_

List two emergency contact persons:

Name \_\_\_\_\_ Address \_\_\_\_\_ phone \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ phone \_\_\_\_\_

Please list persons authorized to pick up your child & a phone # for each contact:

Does your child have any special needs that we should be aware of? \_\_\_\_\_

Is your child fully immunized? Yes No *(Please enclose a copy of your child's immunization record-they may not begin school without this.)*

Does your child have any allergies that require prescribed medication? \_\_\_\_\_

How did you hear about our preschool? \_\_\_\_\_

Please list your child's physician \_\_\_\_\_

Clinic \_\_\_\_\_ Address \_\_\_\_\_ phone # \_\_\_\_\_

Please list your child's dentist \_\_\_\_\_

Address \_\_\_\_\_ phone # \_\_\_\_\_

Will this be your child's first experience in a group? *(Sunday School, preschool, or daycare)* \_\_\_\_\_

Is there any other information you would like us to know about your child? \_\_\_\_\_

## **ADMISSION AGREEMENT:**

I have attached the NON-REFUNDABLE registration and supply fee. I hereby agree to pay the tuition monthly on or before the 5th of each month and I am agreeing to enroll my child for the school year.

Signed \_\_\_\_\_ Date \_\_\_\_\_

For office use: Amount paid \_\_\_\_\_ Check # for registration fee \_\_\_\_\_

# HEALTH CARE SUMMARY



**MUST BE COMPLETED BY HEALTH CARE SOURCE**

Date of Enrollment \_\_\_\_\_

NAME OF CHILD \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ TELEPHONE \_\_\_\_\_

PARENT(S) OR GUARDIAN \_\_\_\_\_

Date of last physical examination \_\_\_\_\_ 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 (including allergies to medications)? \_\_\_\_\_

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 below the important health problems:

<u>Important Health Problems</u>	<u>Followed By You</u>	<u>Followed by Other Medical Sources</u>	<u>Requires Special Attention at Center</u>

Other information helpful to the child care program \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Signature of Health Care Source**

\_\_\_\_\_

**Date**

\_\_\_\_\_

Phone \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_



408 Elm Street West  
Detroit Lakes, MN 56501  
(218) 847-2266  
(218) 847-3011 (fax)

cacdl@arvig.net  
www.cacdl.com

Preschool Teacher:  
Nelaina Daggett

## Medical Information Form

In case of an emergency I understand that every effort will be made to contact me. If I cannot be reached, I hereby give Community Alliance Church of Detroit Lakes, Minnesota permission to act in my behalf in seeking emergency treatment for my child in the event that such treatment is deemed necessary by Community Alliance Church. I give permission to those administering emergency treatment to do so using those measures deemed necessary. I absolve Community Alliance Church from liability in acting on my behalf in this regard so long as Community Alliance Church is not grossly negligent.

Name \_\_\_\_\_ Birth date \_\_\_\_\_

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

Social Security Number (optional) \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

Alternative Contact Person \_\_\_\_\_ Phone # \_\_\_\_\_

Nearest Relative or Friend-Name \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance CO. \_\_\_\_\_ Policy/Group No. \_\_\_\_\_

Allergies \_\_\_\_\_ Medication \_\_\_\_\_

Medication Allergies \_\_\_\_\_

Additional information \_\_\_\_\_

School Year \_\_\_\_\_

Parents/Guardian signature

\_\_\_\_\_

Date

\_\_\_\_\_