PARSIPPANY-TROY HILLS TOWNSHIP

PRESCHOOL TUITION PROGRAM
REGISTRATION FORM 2016 - 2017

Today's Date:_____ **Enrollment Entry Date:**_____

3 YR. OLDS 9-11:30 AM 4 YR. OLDS 12:30-3:00 PM

☐ Lake Hiawatha (LH) ☐ Eastlake (EL) ☐ Littleton (LT)

☐ 3 year olds (LH) ☐ 5 sessions/week ☐ 3 sessions/week M, W, F
☐ 3 year olds (EL) ☐ 5 sessions/week ☐ 3 sessions/week M, W, F
☐ 3 year olds (LT) ☐ 5 sessions/week ☐ 3 sessions/week M, W, F
☐ 4 year olds (LH, EL, LT) ☐ 5 sessions per week

Student Name: _____ ☐ Male ☐ Female
(First) *(Last)*

Student's Home Address: _____
(*Street)* (*PO Box)*

_____
(City) (State) (Zip)

Family Phone: _____ Birth Date: _____

Birth Place: (City, State or Country) _____Date Entered USA: _____

Evidence of Proof of Age: _____

Siblings in District:_____

Ethnic Group: ☐ White ☐ Black/African American ☐ Hispanic ☐ Asian ☐American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ 2 or more races ****Check all that apply.**

What is the primary language spoken at home: _____

Parent/Guardian Name: _____
(PRIMARY) *(Last)* *(First)*

Relationship to child: Mother ☐ Father ☐ Other: _____

Mailing Address: _____
(if different from student's)

Cell Phone: _____ Work Phone: _____

Email:_____

Parent/Guardian Name: _____
(SECONDARY) *(Last)* *(First)*

Relationship to child: Mother ☐ Father ☐ Other: _____

Mailing Address: _____
(if different from student's)

Cell Phone: _____ Work Phone: _____

Parent/Guardian's marital status: Single☐ Married☐ Divorced☐ Separated☐
Widow☐ Widower☐ Civil Union ☐

Comment: _____

MEDICAL INFORMATION

Does your child have any allergies? Food, medication, latex, bee stings etc.☐ No ☐ Yes
If **yes**, please list _____
Does your child have any medical conditions? ☐ No ☐ Yes
If **yes**, describe: _____

_____

Does your child have asthma? ☐ No ☐ Yes
If **yes**, does your child use an inhaler? ☐ No ☐ Yes
Will it be necessary to keep an inhaler in the nurse's office? ☐ No ☐ Yes
Is your child taking any medication? ☐ No ☐ Yes
If **yes**, please list _____

In the event of an extreme emergency, if parent, guardian or emergency contacts cannot be reached, I give permission to the school authority to arrange appropriate medical care at _____Hospital or other medical or dental facility.

Person to be called if parent is not available. (Please list in order of preferred contact.)

1. _____ Telephone No.: _____

Relationship: _____

2. _____ Telephone No.: _____

Relationship: _____

I have arranged for the above to care for my child in case of illness or emergency. You may call our family physician, if necessary.
Physician to call _____ Telephone No.: _____
Other person(s) authorized to pick up your child:
_____ Telephone No.: _____

_____ Telephone No.: _____

Printed Name _____ Date _____

Signature _____

PACE
Calabria Education Center
Parsippany-Troy Hills Board of Education
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Parsippany, NJ 07054
973-263-7200 Ext. 3021
Fax: 973-263-7216

PAYMENT

AUTOMATIC MONTHLY PAYMENT

I authorize the PACE office to charge the credit card listed below on the 15th of each month for preschool tuition. I understand that I may rescind this request at any time by notifying the PACE office.

Name as it appears on credit card:_____

____ Visa ____MC ____Disc

Credit Card #_____Expiration Date_____

3 Digit Security Code on back of card:_____

ELECTRONIC FUND TRANSFER

I authorize the PACE office to transfer funds from the account listed below on the 15th of each month for preschool tuition. I understand that I may rescind this request at any time by notifying the PACE office.

Name as it appears on the account_____

Bank Name_____

Routing # _____Account # _____

Child's Name:_____ Age:_____