



**St. Paul's Evangelical Lutheran Church
HILLTOP CHRISTIAN NURSERY SCHOOL
837 Charles Street, Torrington, CT 06790
Phone: 482-3727**

St. Paul's Hilltop Christian Nursery School Registration

ABOUT THE CHILD

Last Name _____ First Name _____ Middle Initial _____

Name you would like your child to know/recognize _____

Child's Address _____ Telephone #(____) _____

City/State/Zip _____ Date of Birth ____/____/____ Male Female

Optional Race/Ethnic Category: American Indian Asian Black, not of Hispanic Origin

White, not of Hispanic Origin Hispanic/Latino Other _____

About The Parents

Father's Full name _____ e-mail address _____

Father's Address: Same as child's or: _____

Occupation _____ Employer _____ Town _____

Phone Numbers: Work (____) _____ ext ____ Cell (____) _____ Other (____) _____

Mother's Full name _____ Maiden name _____ e-mail address _____

Mother's address: Same as child's or: _____

Occupation _____ Employer _____ Town _____

Phone Numbers: Work (____) _____ ext ____ Cell (____) _____ Other (____) _____

Child's Living Arrangement:

LIVES WITH: Both Parents Mother Father Guardian * Other * *Relationship to Child _____

*Full Name (if other than parent) _____

*Address _____ City/State/Zip _____

*Phone Numbers: Work (____) _____ ext ____ Cell (____) _____ Other (____) _____

Family Languages:

What language did your child learn to speak first? _____

What is the primary language spoken by parents or guardians in the home? _____

What is the primary language spoken by your child at home? _____

Who speaks English in your home? Father Mother Other _____

Additional Questions:

How did you hear about Hilltop? _____

Are you an active member of St. Paul's Yes No

Do you have a child currently enrolled in Hilltop Yes No

(over)

Local people to contact when parents are unavailable:

Full name of 1st contact: _____ Telephone # (____) _____
 Address _____ Relationship _____
 Full name of 2nd contact: _____ Telephone # (____) _____
 Address _____ Relationship _____
 Full name of 3rd contact: _____ Telephone # (____) _____
 Address _____ Relationship _____

Names of Child's Brothers	Age	Date of Birth		Names of Child's Sisters	Age	Date of Birth

Child's Health History

Physician's Name _____ Town _____ Phone # (____) _____

Is your child regularly or intermittently on any medications? Yes No

If yes, please name the medication(s) _____

How often is it given? _____

Doctor that ordered the medication: _____ Town _____ Phone # (____) _____

Does your child have asthma? Yes No

Does your child use an inhaler or nebulizer (electronic machine with inhaler medication)? Yes No

If yes, how often? Seasonally only Regularly throughout the year Only when ill

List your child's allergies (food, medications, seasonal, other) _____

Is your child prescribed an Epi Pen? Yes No

PLEASE NOTE: Your child must be potty trained at the beginning of the school year.

Additional comments from parents/guardians:

of additional pages attached: _____

PLEASE CIRCLE YOUR CHOICE

3 YEAR-OLD CLASSES

2 days MON/WED 9:00 to 11:30
 2 days TUES/THURS 9:00 to 11:30

4 YEAR-OLD CLASSES

2 days TUES/THURS 9:00 to 11:30
 3 days MON/WED/FRI 9:00 to 11:30
 4 days TUES/WED/THURS/FRI 12:15-2:45
 (Child must be 5 by June 1, 2011 to qualify for Pre-K class)

Please indicate whether the PM class would be acceptable if the AM classes are filled before your application is received _____

Parent's\Guardian's Signature _____ Date _____

PLEASE INCLUDE A \$50.00 registration fee. This fee is NON-REFUNDABLE.

PLEASE MAKE CHECKS PAYABLE TO: ST. PAUL'S Check# _____ Cash _____ Date _____ Time _____