

<u>Fees Due</u>		<u>Fees Received</u>		<u>Office Use Only</u>	
Application Fee	\$ 100.00	Check #	_____	Medical Concern	_____
Materials Fee	\$ 125.00	Amount \$	_____	Custody Concern	_____
1 <sup>st</sup> Tuition Installment	\$ _____			Birth Certificate	_____
Total Due	\$ _____				



## The Ark Children's Center

3425 Emory Church Road | Olney, MD 20832  
301-774-5369 | www.oakdale.church/ark

### 2020-2021 REGISTRATION FORM

Today's Date \_\_\_\_\_ Current Student/Sibling \_\_\_\_\_ OEUMC Member \_\_\_\_\_ Alumni \_\_\_\_\_ Community \_\_\_\_\_

Please carefully indicate program registering for:

_____ 2 year old program	MWF 9-12 Noon	\$ 4120.00 yrly	Must be 2 by Sept. 1, 2020
_____ 2 year old program	T,TH 9-12 Noon	\$ 2750.00 yrly	Must be 2 by Sept. 1, 2020
_____ 3 year old program	MWF 9-1 PM	\$ 3800.00 yrly	Must be 3 by Sept. 1, 2020
_____ 3 year old program	T,TH 9-1 PM	\$ 3100.00 yrly	Must be 3 by Sept. 1, 2020
_____ 4 year old program	MWF 9-1 PM	\$ 3950.00 yrly	Must be 4 by Sept. 1, 2020
_____ 4 year old program	M-F 9-1 PM	\$ 6050.00 yrly	Must be 4 by Sept. 1, 2020

Child's Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Name by which your child is called \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (Month/Day/Year) Gender of Child \_\_\_\_\_

Address: Street \_\_\_\_\_

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

E-mail Address: \_\_\_\_\_

Mother/Guardian \_\_\_\_\_ Father/Guardian \_\_\_\_\_

Address (if different) \_\_\_\_\_ Address (if different) \_\_\_\_\_

Cell Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Home Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Occupation \_\_\_\_\_

### PERSONAL INFORMATION

Child lives with: ( )Both Parents ( )Mother ( )Father ( )Adoptive ( )Other \_\_\_\_\_

Custody Concerns: ( )Yes ( )No If yes, documentation required.

(COMPLETE REVERSE SIDE>>>>)

**(Personal Information Continued)**

Siblings: Name	Date of Birth	Name	Date of Birth
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

Does your child attend religious services? \_\_\_Yes \_\_\_ No      Sunday School? \_\_\_Yes \_\_\_No

Place of Worship? \_\_\_\_\_

Language spoken at home \_\_\_\_\_

Child's Bedtime \_\_\_\_\_      Nap Routine \_\_\_\_\_

Is this your child's first preschool experience? ( )Yes ( ) No      Name of Program: \_\_\_\_\_

Does your child have any great fears? \_\_\_\_\_

Does your child cry easily? \_\_\_\_\_ Your child's typical mood is \_\_\_\_\_

What types of discipline techniques are used at home? \_\_\_\_\_

Is your child toilet-trained? ( )Yes ( )No

Does your child express any concerns with toileting? \_\_\_\_\_

**Specify child's allergies** \_\_\_\_\_

**Will your child require possible medical intervention at school?** \_\_\_Yes \_\_\_No

Explain (please call the office to request a Medical Authorization Form or visit [www.oakdale.church/ark](http://www.oakdale.church/ark) and print a copy—this form will need to be completed by your pediatrician):

Is your child currently receiving speech & language services or other support services? Explain:

**Please list any other concerns:**