



Registration 2018-2019

St. Mark's Lutheran Preschool
454 Fieldstone Rd.
Mooresville, NC 28115
(704)-664-2009

To complete enrollment, return along with \$90.00 registration fee to St. Mark's Lutheran Preschool.

Child's Name _____
First Middle Last

Nickname/ Name preferred to be used _____

Date of Birth _____ Class Age as of Aug. 31, 2018 _____

Address _____
Number and Street City State Zip P. O. Box

Email Address _____

Cell Phone (Mom) _____

Cell Phone (Dad) _____ **Please place asterisk next to preferred 1st contact #**

Home Phone _____

Mother's Name _____ Occupation _____

Place of Employment _____ Work Phone _____

Father's Name _____ Occupation _____

Place of Employment _____ Work Phone _____

Parents' Marital Status: Married ___ Divorced ___ Separated ___ Single ___ Other ___

Step Parents _____

Other Children in Family _____

Are there any food allergies, severe allergies, or health concerns? _____

Are there any diagnosed or suspected learning difficulties? _____

Has your child previously attended preschool? Yes No Where? _____

Please share any other information which might be helpful to the teacher.

Church Membership _____

Please list others who may pick up your child.

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Emergency Contact Persons If Parents Cannot Be Reached

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Emergency Information

Child's Doctor _____ Phone _____

Insurance Provider _____ Policy # _____

**St. Mark's Lutheran Preschool
454 Fieldstone Road
 Mooresville, N. C. 28115
704-664-2009
Fax 704-660-7737**

Physician's Statement

I have examined _____ and find that this child is in
Child's name
good health, and I am aware of no limitations to his or her participation in the normal
activities of a preschool child.

I have noted the following, if applicable:

Known food allergies/ other severe allergies _____

Special attention and care is needed for _____

Developmental concerns _____

Physician's Signature _____ Date _____

Office Name _____ Phone # _____

Please attach a copy of the child's immunization records.