365 Broadway · Hillsdale, NJ · T 201.722.8500 · F 201.722.9613
www.lovingtouchnurseryschool.com

Please return all completed forms along with 2 checks:

Registration Fee: $200.00

Tuition Deposit: $_____

Tuition deposit will be used towards your child's last month in our program. Registration fees are nonrefundable.

Registration fee is an annual fee.

Also, please contact your pediatrician's office and have them fax us an updated copy of your child's immunization records.

Our fax number is (201) 722-9613.

_____

Parent Signature

Thank you,

Loving Touch Nursery School

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Name of Child: _____

Age Starting: _____ Date of Birth: _____

Address: _____

Home Phone #: _____ E-Mail Address: _____
Mother Cell Phone #: _____ Father Cell Phone #: _____

Business Information: (Name of Company, Address and Phone #)

Mother: _____

_____

Father: _____

_____

Program (Class and Days): _____

Hours: _____
Start Date:_____

A Registration Fee & Tuition Deposit
Must Accompany This Application.

Paid: $_____ Check #: _____ Date: _____

Paid: $_____ Check #: _____ Date:_____

Parent Signature: _____

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Child's Name	Sex	Age	Toiled Trained?
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____

Parent's Name:_____

Address:_____

State:_____Zip:_____Phone:_____

Child's Physician:_____

Address:_____

State:_____Zip:_____Phone:_____

Medical Facts

Allergies:_____

Medications:_____

Communicable Diseases:

Mumps:_____Measles:_____German Measles:_____

Chicken Pox:_____ Other:_____

Date of last Tetanus Shot:_____

In Case of Emergency Contact:

Name:_____Phone: _____

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I would like Loving Touch Nursery School to contact Mother/Father **first**,
(Circle one)
in case my child becomes ill or is injured:

Phone #: _____

I give my consent for my child's doctor to treat my child if he/she becomes ill or is injured.

Doctor's Name: _____ Phone #: _____

Address: _____ Town: _____

If the above named doctor is not available, Loving Touch may take my child to Valley Hospital.

I give permission for Valley Hospital and/or _____
to treat my child for any and all medical needs. (other medical facility)

_____ _____ _____
Child's Name Parent's Signature Date

_____ _____
Witnessed By Date

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I hereby grant permission for my child to use all of the play equipment and participate in all of the activities of the school, and to leave the school premises under the supervision of a staff member for scheduled field trips.

I hereby grant permission for Loving Touch Nursery School to take whatever steps may be necessary to obtain emergency medical care.

These steps may include, but are not limited to, the following:

1. Attempt to contact a parent or guardian, the child's physician, or person listed on the emergency form.

2. If we cannot you or your child's physician we will do one or both of the following:

   (a) Call another physician or paramedics
   (b) Have your child taken to an emergency hospital in the company of a staff member.

3. The school will not be responsible for anything that may happen as a result of false information given at the time of enrollment.

4. The school will not assume responsibility for a child who has not been signed in upon arrival for the day.

Signed: _____ Date: _____

Signed: _____ Date: _____

Witnessed: _____ Date: _____

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Persons authorized to pick up child:

Name: _____

Address:_____

_____

Relationship:_____

Home Phone:_____

Business Phone:_____

Name: _____

Address:_____

_____

Relationship:_____

Home Phone:_____

Business Phone:_____

Name: _____

Address:_____

_____

Relationship:_____

Home Phone:_____

Business Phone:_____

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PHOTO PERMISSION PAGE

I give my permission for _____ to be photographed, videotaped and/or featured on Loving Touch Nursery School's Facebook page by a member of Loving Touch Nursery School management and/or local news organizations approved by and accompanied by the Director for purposes of advertising, public relations and family enrichment. I give Loving Touch Nursery School permission to have my child photographed by members of the press at the facility for public relations purposes at any time.

Parent's Signature_____Date_____

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Emergency Contact Sheet:

Child's Name: _____

Parents Names: _____

Mom Work #: _____

Mom Cell #: _____

Dad Work #: _____

Dad Cell #: _____

If we cannot reach you please leave an emergency contact:

Name: _____ Phone #: _____

Relationship to Child: _____

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CERTIFICATE OF GOOD HEALTH

_____ was seen in our office on

_____ (Date)

He/She is in good health and has no restrictions or allergies, unless otherwise noted below.

Comments:

_____
_____
_____
_____
_____
_____
_____

Physician's Signature: _____

Physician's Print Name: _____

Date: _____