

St. Philip Lutheran Preschool
7304 Falls of Neuse Road 27615
2025-2026

Name _____ Date of Birth _____

Please **CIRCLE** the class in which you wish to enroll: (birthday cut-off October 16)

- 2 year class – Monday & Wednesday
- 2 year class – Tuesday & Thursday
- 3 year class – Tuesday & Thursday
- 3 year class – Monday, Wednesday, Friday
- 4 year class – Monday, Wednesday, Friday
- 4 year class – Monday – Friday
(2,3,4 year classes 9:00-12:00)
- Kindergarten – Monday - Friday
(9:00-1:00 Mon-Thur & 9:00-12:00 Fri)

Parents' Name _____

Address _____

Home Telephone _____ Business _____

E-Mail _____

Church Preference _____

Church Address _____

Each child must have proof of immunizations/No medical or religious exemptions

GENERAL INFORMATION

A registration fee of one month's tuition must be paid at time of registration to hold your child's spot. THIS FEE IS NON-REFUNDABLE unless you move out of the county. When the form is returned to school, your child will be placed on a class roll. A letter of acceptance will be mailed to you in JULY. Parents may contact the Director to confirm a place in a class as soon as the forms have been returned.

Tuition is paid monthly due on the 15th of each month. The first month's tuition is due on August 15th and the 15th of each subsequent month with the final payment due April 15th.

TUITION SCHEDULE

2 day classes	\$260	2 year old 4 days	\$420
3 day classes	\$330		
5 day class	\$390	3 year old 5 days	\$490
Kindergarten	\$420		

If you have any questions about enrollment or the program, please contact the Director at 919-870-5841 or 919-818-9585.

St. Philip Lutheran Preschool admits students of any race, color and national or ethnic origin.

Date_____

Application for _____
last first middle name uses

Date of Birth _____ Sex _____ Phone _____

Address _____

Father's
Name _____ Bus/CellPhone _____

Occupation & Address _____

Mother's
Name _____ Bus/CellPhone _____

Occupation & Address _____

Siblings (names & ages) _____

Other adults in the home _____

Language other than English used in the home _____

Previous schools attended _____

IN CASE OF EMERGENCY – Responsible party to call if parent cannot be reached.

Name _____ Phone _____

IN CASE OF MEDICAL EMERGENCY

Physician _____ Phone _____

Any concerns about your child's general health? _____

Any allergies? _____

Explain any speech problem. _____

Problems with toilet habits? _____
(must be potty trained before coming to the 3 year class)

Any unusual fears? _____

Excessive jealousy? _____

Nail biting, thumb sucking, etc? _____

Have trouble handling anger? _____

Does your child use one hand in preference to the other? _____

With whom does your child usually play? _____

Is there any additional information about your child, which might help the teachers in working with your child? _____

Do you have any concerns about your child's behavior or emotional well-being that the teachers should be aware of? _____

What are your goals and expectations for your child in the coming year? _____

How did you learn about St. Philip? Friend(name) _____, Website _____,

Facebook _____, Church Bulletin _____, other _____

Parent Signature: (Choose ONE)

_____ I give permission for St. Philip Preschool to use photos (no names) of my child on the preschool website, Facebook page, or brochure.

_____ Date _____

_____ I DO NOT give permission for St. Philip Preschool to use photos of my child on the preschool website, Facebook page, or brochure.

_____ Date _____

MEDICAL INFORMATION

Child's Name _____ Birth Date _____

Parents _____

Address _____

History:

Allergies _____ ChickenPox _____ Measles _____ Mumps _____

Whooping Cough _____ Rheumatic Fever _____ Diabetes _____

Epilepsy _____ Tuberculosis _____ Asthma _____

Chronic Colds _____ Chronic Sore Throats _____ Chronic Ear

Infections _____ Nosebleeds _____ Drug Sensitivities _____

PX: Head _____
Heart _____
Eyes _____
Ears _____
Nose _____
Mouth _____
Extremities _____

Abdomen _____
Lungs _____
Vision _____
Hearing _____
Adenoids _____
Tonsils _____

Record of Immunization:

	1st dose	2 nd dose	3 rd dose	4 th dose
DTaP	_____	_____	_____	_____
Polio	_____	_____	_____	_____
MMR	_____	_____	_____	_____
Hib	_____	_____	_____	_____
Hep B	_____	_____	_____	_____
Varivax	_____	_____	_____	_____

Do you recommend this child for Preschool? YES _____ NO _____
Are there any medical conditions, operations, accidents that we should be aware of? _____

Physician's Signature _____ Date _____