



FIRST BAPTIST CHURCH OF ST. CHARLES PRESCHOOL CENTER

136 Stoddert Avenue, Waldorf, MD. 20602 (301) 374-6856

Half Day Class: Young 4's/4 Yr. Old Pre-K _____

Extended Day Classes: 3 Yr. Old _____ 4 Yr. Old Pre-K _____

Interested in: Before and After Care: _____ Before Care: _____ After Care: _____

Hours/Days I would need my child to be in Before and/or Aftercare: _____

APPLICATION FOR ENROLLMENT (PLEASE PRINT)

Child's Name: _____ **Name called:** _____
Last Name First Middle

Address: _____
Street City/State Zip Code

Neighborhood or Subdivision: _____

Telephone: _____ **Birthday:** _____ **Age:** _____ **Sex:** _____

Name of Father: _____ **Age:** _____

(Parent _____ StepFather _____ Legal Guardian _____)

Address: _____ **Home Phone:** _____

Email Address: _____

Father's Place of Employment: _____

Type of Work (in Preschool Language – Carpenter, Pilot, Etc.): _____

Business Phone: _____ **Cell Phone:** _____

Name of Mother: _____ **Age:** _____

(Parent _____ Stepmother _____ Legal Guardian _____)

Address: _____ **Home Phone:** _____

Email Address: _____

Mother's Place of Employment: _____

Type of Work (in Preschool Language – Teacher, Doctor, etc.): _____

Business Phone: _____ **Cell Phone:** _____

***** (If custody is an issue, we must have a copy of custody papers to keep on file.) *****

Is child now staying with a Day Care Provider? ____ If so, how long has he/she been with current provider? ____

Day Care Provider's Name: _____ Phone: _____

Previous Preschool/Center Experience: _____

Do both parents now live with child? _____

List all children/persons living in the home (Please include ages and relationship to child): _____

(If additional space is needed use back of application)

Family Pets and their names: _____

Is Your child Toilet Trained? Yes ____ No ____ At what age? _____

(Children must be completely toilet trained by the start of school.)

Is there any reason (medical, etc.) why your child might need assistance? _____

List congenital conditions, unusual injuries, operations, and traumatic experiences which the child has had.

List foods that your child is unable to eat (medical reasons, religion, etc.): _____

Does your child have any fears? _____

List any language other than English spoken in the home: _____

Does your child speak English fluently? _____

How does he/she behave when upset, angry or afraid? _____

What are the most important "do's and do not's" in your family for your child? _____

What type of discipline is used at home? _____

Our program is inclusive of all children including those with special health care needs or disabilities to the best of our abilities. We will work with special service providers and families to meet the needs of your child. If your child has an IEP or IFSP, we request a copy.

****If your child needs to keep medication at school, has severe allergies, asthma or has seizures please ask for appropriate forms, as they will need to be completed by your doctor before the start of school.**

Which of the following does your child now have or is inclined to have?

- | | | |
|---|--|--|
| <input type="checkbox"/> Speech difficulties | | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Has been evaluated for speech | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Temper tantrums |
| <input type="checkbox"/> Receiving speech services now | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Persistent crying |
| <input type="checkbox"/> Hearing difficulties | | <input type="checkbox"/> Finger/Thumb sucking |
| <input type="checkbox"/> Eye complaints/ Wears Glasses? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Nail biting |
| <input type="checkbox"/> Epilepsy attacks | | <input type="checkbox"/> Trouble going to the bathroom |
| <input type="checkbox"/> Earaches | | <input type="checkbox"/> Separation Anxiety |
| <input type="checkbox"/> Hay fever | | Other- (list below) |
| <input type="checkbox"/> Asthma | | _____ |
| <input type="checkbox"/> Allergies (list below) | | _____ |

Does your child have an IEP/IFSP?
If so, please provide a copy with this form

Please give us any other information which may help us work more effectively with your child. (Such as special likes or dislikes, unusual habits, strong attachments to a toy or other objects, or medical problems.)

Religious Affiliation if any: _____
Name of Church you attend: _____
Does your child attend Sunday School? _____
Would you like information about The Church @ St. Charles? _____

We accept Maryland's Childcare Scholarship Program.
If you would like more information or will be using the Scholarship Program, please check here _____

A \$80.00 non-refundable registration fee is to be submitted with this application.

I understand the one month's advance tuition is due by June 1, 2024.

This non – refundable advance payment will be credited to May 2025 tuition.

Date: _____ Signature: _____