LIVING SAVIOUR LUTHERAN PRESCHOOL
Address: 6817 Carmel Rd. Charlotte, NC 28226
Phone: (704) 542-9110

Camp is open to: rising 3-year old's through rising kindergarteners

Registration Form Summer 2025

Child's Name: _____Gender: _____DOB: _____/_____/_____

Is Child FULLY potty trained? YES or NO

Mother's Name: _____ Father's Name: _____

Child's Home Address: _____

Home Phone: _____ Email (REQUIRED): _____

Mother's Cell: _____ Father's Cell: _____

PLEASE CHOOSE YOUR WEEKS, BY MARKING AN X IN THE CORRSPONDING BOXES BELOW

SUMMER HOURS: MONDAY-THURSDAY (NO FRIDAYS) 9:25-1:00PM

	M-TH $125 WEEKLY* (no refunds)
WEEK 1: 6/2-6/5	
WEEK 2: 6/9-6/12	
WEEK 3: 6/16-6/19	
WEEK 4: 6/23-6/26	
NO CAMP	
WEEK 5: 7/7-7/10	
WEEK 6: 7/14-7/17	
WEEK 7: 7/21-7/24	
WEEK 8: 7/28-8/31	

Tuition for weeks 1-4 due May 15: _____

Tuition for weeks 5-8 due by June 13: _____

****Please complete front and back of form****

Getting To Know Your Child

HELP THE TEACHERS BECOME BETTER ACQUAINTED WITH YOUR CHILD. (All information will be kept confidential.)

Child's Name: _____ Child's Nickname: _____
Is this your child's first preschool experience? _____ Is your child toilet trained? _____

Known Allergies: Yes_____ No_____ If yes, please list. _____

Does your child take any medication* on a regular basis? _____ If yes, please specify: _____

_____

Are there any foods that your child cannot eat? If yes, please list: _____

_____

If you have listed any foods they cannot have, is it due to a religious reason or a food allergy*? _____

Does your child have any medical conditions, special needs, developmental delays or behavioral issues in which the school should be aware of so we can better minister to your family?_____ If yes, Please explain

_____

_____

Please Note: For Liability purposes we cannot administer medications (other than an EPI-PEN)
ANY ALLERGY THAT IMPACTS THE CLASSROOM WILL REQUIRE A DOCTOR'S NOTE DESCRIBING THE ALLERGY, THE SEVERITY, and THE APPROPRIATE RESPONSE.

Pick Up Authorization

I hereby give permission for the following person(s) to pick up my child.
Any exceptions to the following list must be received from the parents in written form.

#1 Name _____
Relationship to child: _____
#2 Name _____
Relationship to child: _____
#3 Name _____
Relationship to child: _____
#4 Name _____
Relationship to child: _____

Emergency Contacts (*Please list 2*)

#1 Name_____
Relationship to child: _____
Cell_____
Home _____
Work_____
#2 Name_____
Relationship to child: _____
Cell_____
Home _____
Work_____

Emergency Medical Release Form

Child's Name_____

Medical Authorization: I understand that, in case of medical emergency every effort will be made to contact the parents or guardians. In the event, I cannot be reached, I give permission for Living Saviour Lutheran Preschool and or the physician named below to treat my child.

Child's Doctor: _____ Phone: _____

Child's Dentist_____ Phone: _____

Insurance Company_____ Policy# _____

Hospital Preference: _____

Signature (Parent/Guardian) _____ Date _____