Dear Parents,

 We have had to raise our tuition fees due to our operating costs and to insure we have and can keep quality teachers. This has been a struggle for us, as we have only raised our tuition two times since we have been operating. We have prayed about this and hope you will understand and support this decision. We would also like to let you know that the school year 2025-2026 will be our last year of operation. It breaks our hearts, but our enrollment continues to drop in numbers.

 Please fill out all forms completely with telephone numbers, addresses, and signatures. Then send the forms plus $30 registration fee back to Hilltop as soon as possible. This will guarantee your spot for next fall. Your child is required to have a medical examination and lead test form and a copy of their immunizations before the 1st day of school.

 Thank you.

 Ms. Tracy

Contact information:

Director of Hilltop: Tracy Ryan 417-551-9684

Email: hilltopdirector@ozarkumc.org

Ozark United Methodist Church 417-581-6853

Mailing address: 2850 State Highway 14 East Ozark , MO 65721

 **HILLTOP PRESCHOOL ENROLLMENT**

NAME OF CHILD

NAME OF PARENTS

 Parents live together? YES\_\_\_\_ NO\_\_\_\_\_\_

HOME PHONE NUMBER

MOM'S CELL# DAD'S CELL#

E-MAIL

DOES YOUR CHILD HAVE ANY SPECIAL NEEDS?

IS THIS THE FIRST TIME THAT YOUR CHILD HAS BEEN IN PRESCHOOL?

 How did you hear about our preschool program?

 SIBLINGS NAMES & AGES

This Year we are only offering one class for each classroom.

 **(YOUR CHILD MUST BE 4 BY AUGUST 1 TO ENROLL IN THIS CLASS)**

**\_\_M-W-F 4'S MORNING CLASS (MEETS 9:00 AM-12:00 PM) $200 PER MONTH**

(**YOUR CHILD MUST BE 3 BY AUGUST 1 AND FULLY POTTY TRAINED TO ENROLL IN THIS CLASS)**

**\_\_MON-WED-FRI 3's MORNING CLASS (MEETS 9:00 AM -12:00 PM) $200 PER MONTH**

(Return with enrollment fee)

 **RELEASE FORM**

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I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give permission *.*tothe following people topick up mychild from school.

 **NAME**  **PHONE NUMBER**

##

##

## Iunderstand that my child will not be released to ANYONE not on the above list.

## Parent Signature Date

Any person that the teacher has not- met before or does not know will NEED TO\_SHOW A PICTURE IDENTIFICATION (such as a driver's license) before the child will be released.

(Return with enrollment fee)

|  |  |
| --- | --- |
| I:\Childcare\Photos\State_Seal_Color.png | MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES SECTION FOR CHILD CARE REGULATION**CHILD CARE ENROLLMENT FORM FOR LICENSE-EXEMPT FACILITIES** |
| FACILITY/PROVIDER NAMEHILLTOP PRESCHOOL | ADMISSION DATE | DISCHARGE DATE |
| CHILD’S NAME | GENDER | BIRTHDATE |
| ADDRESS (STREET, CITY, STATE, ZIP CODE) |
| **IDENTIFYING INFORMATION** |
| MOTHER’S/GUARDIAN’S NAME | HOME TELEPHONE NUMBER |
| ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE | CELL PHONE NUMBER |
| E-MAIL ADDRESS |
| EMPLOYER OR SCHOOL ATTEND | WORK/SCHOOL SCHEDULE |
| EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE) | WORK TELEPHONE NUMBER |
| FATHER’S/GUARDIAN’S NAME | HOME TELEPHONE NUMBER |
| ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE | CELL PHONE NUMBER |
| E-MAIL ADDRESS |
| EMPLOYER OR SCHOOL ATTEND | WORK/SCHOOL SCHEDULE |
| EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE) | WORK TELEPHONE NUMBER |
| **EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY**(OTHER THAN PARENT) AT LEAST ONE EMERGENCY CONTACT IS REQUIRED. |
| NAME | RELATIONSHIP TO CHILD | TELEPHONE NUMBERS (CELL, WORK, HOME) |
| ADDRESS (STREET, CITY, STATE, ZIP CODE) |
| NAME | RELATIONSHIP TO CHILD | TELEPHONE NUMBERS (CELL, WORK, HOME) |
| ADDRESS (STREET, CITY, STATE, ZIP CODE) |
| **AUTHORIZATION FOR EMERGENCY MEDICAL CARE** |
| I UNDERSTAND THAT I WILL BE NOTIFIED AT ONCE IN CASE OF AN EMERGENCY WITH MY CHILD, AND I WILL MAKE ARRANGEMENTS FOR MEDICAL CARE OF MY CHILD WITH THE PHYSICIAN OR HOSPITAL OF MY CHOICE.IF I CANNOT BE REACHED TO MAKE NECESSARY ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZEHILLTOP PRESCHOOLDAY CARE PROVIDERTO CONTACT THE FOLLOWING: |
| **PHYSICIAN OR CLINIC** |
| NAME | TELEPHONE NUMBER |
| **PREFERRED HOSPITAL** |
| NAME | TELEPHONE NUMBER |

 (Return with enrollment fee)

MO 580-2124 (8-15) **PLEASE ALSO COMPLETE PAGE 2.** DC-105 PAGE 1

|  |
| --- |
| **ACKNOWLEDGEMENTS** |
| A | I HAVE BEEN INFORMED OF THE REQUIRED HEALTH AND SAFETY INSPECTIONS AND THE INSPECTION FORMS ARE AVAILABLE FOR REVIEW. | PARENT/GUARDIAN INITIALS |
| B | WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT S/HE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE. | PARENT/GUARDIAN INITIALS |
| C | I DODO NOT GIVE PERMISSION FOR FIELD TRIPS/EXCURSIONS.I UNDERSTAND I WILL BE NOTIFIED IN ADVANCE WHEN THEY ARE PLANNED. | PARENT/GUARDIAN INITIALS |
| D | I DODO NOT GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD. | PARENT/GUARDIAN INITIALS |
| E | I HAVE BEEN NOTIFIED THAT I MAY REQUEST NOTICE AT INITIAL ENROLLMENT OR ANY TIME THERE AFTER WHETHER THERE ARE CHILDREN CURRENTLY ENROLLED IN OR ATTENDING THE FACILITY FOR WHOM AN IMMUNIZATION EXEMPTION HAS BEEN FILED. | PARENT/GUARDIAN INITIALS |
| **HEALTH REPORT FOR SCHOOL-AGE CHILD****CHILD’S HEALTH HISTORY AND CURRENT HEALTH PROBLEMS** |
| MY CHILD IS IN GOOD HEALTH, IS ABLE TO PARTICIPATE IN GROUP CARE, HAS NO SPECIAL HEALTH OR MEDICAL REQUIREMENTS.MY CHILD IS ABLE TO PARTICIPATE IN GROUP CARE BUT HAS SPECIAL HEALTH OR MEDICAL REQUIREMENTS AS LISTED BELOW. |
| ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS |
|  |
| ANY SPECIAL MEDICATIONS AND/ OR RESTRICTIONS |
|  |
| PARENT/GUARDIAN SIGNATURE | DATE  |
| **FORM TO BE RETAINED FOR ONE YEAR AFTER DISCHARGE.****FILING:** FILE FORM IN CHILD’S INDIVIDUAL RECORD. |

MO 580-2124 (11-15) (Return with enrollment fee) DC-105 PAGE 2