



Application for *Parkview Sonshine Academy*
Early Education Center

Welcome!

Thank you for expressing an interest in *Parkview Sonshine Academy*. As part of the application process, we invite you to take a few moments and carefully read through this information packet. We also encourage you to come in and visit the center's facility at *Parkview Christian Academy* on 201 West Center Street, Yorkville. We would love the opportunity to meet with you and tell you what we're about. Please give our office a call if you have any questions. We look forward to serving you and your family in the future.

In His service,

Mrs. Tonya Lempesis, Director
Parkview Sonshine Academy
tlempesis@ParkviewChristian.net
630.553.5158

Submit completed application to the *Parkview Sonshine Academy* office.
A spot will be held once the nonrefundable registration and program curriculum fees have been paid.

Application for Enrollment

For office use only

Entered on computer
Account number
Registration applied
Room assignment



| | | | |
|---------------------------|---|---|---------------------------------|
| Current date: | | Starting date: | |
| Child's full name: | | | |
| | Last | First | Middle |
| Date of Birth: | | <input type="checkbox"/> Male | <input type="checkbox"/> Female |
| Preschool class: | <input type="checkbox"/> 2 year-old <input type="checkbox"/> 3 year-old <input type="checkbox"/> 4 year-old | All Day Care: <input type="checkbox"/> | |

| | | | |
|---------------------------|--|---------------------|--|
| Parent/guardian #1 | | | |
| Mr./Mrs./Ms | | Home phone: | |
| Home address: | | Cell phone: | |
| City/state/zip: | | Lives with student? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Relation to student: | | Billing party? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Employer/occupation: | | Work phone: | |

| | | | |
|---------------------------|--|---------------------|--|
| Parent/Guardian #2 | | | |
| Mr./Mrs./Ms | | Home phone: | |
| Home address: | | Cell phone: | |
| City/ state /zip: | | Lives with student? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Relation to student: | | Billing party? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Employer/occupation: | | Work phone: | |

Other than parents, the child will be released only to persons indicated below (must include at least two local persons to call for illness, accidents, late pick-up, or other emergency reasons). Please list them in the order of preference for us to contact.

| | | | |
|----------------------|--|---------------------|--|
| Mr./Mrs./Ms | | Home phone: | |
| Home address: | | Cell phone: | |
| City/ state /zip: | | Lives with student? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Relation to student: | | Billing party? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Employer/occupation: | | Work phone: | |

| | | | |
|----------------------|--|---------------------|--|
| Mr./Mrs./Ms | | Home phone: | |
| Home address: | | Cell phone: | |
| City/state/zip: | | Lives with student? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Relation to student: | | Billing party? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Employer/occupation: | | Work phone: | |

| | | | |
|----------------------|--|---------------------|--|
| Mr./Mrs./Ms | | Home phone: | |
| Home address: | | Cell phone: | |
| City/state/zip: | | Lives with student? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Relation to student: | | Billing party? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Employer/occupation: | | Work phone: | |

| | | |
|---|--|--|
| Special physical conditions/allergies we should be aware of: | | |
| Names and ages of other children in the family: | | |
| Has your child ever been in an early education center before? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, where? | | |
| Church membership or religious preference: | | |
| Medical Information | | |
| Name of child's physician or clinic: | | |
| Physician or clinic address: | | Phone: |
| Name of medical insurance: | | Insurance policy #: |
| Date when child was last examined by a physician: | | |
| Consent to Medical Care and Treatment of Minor Child | | |
| I, _____ (<i>name of natural parent or legal guardian</i>), hereby give permission for my child _____ (<i>name of child</i>) to be given emergency treatment, to include first aid and CPR by a qualified staff member of <i>Parkview Sonshine Academy</i> or <i>Parkview Christian Academy</i> . I further authorize and consent to medical, surgical, and hospital care, treatment, and procedures to be performed for my child by my child's regular physician, or when that physician cannot be reached, by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health if I cannot be contacted. In such a case, I waive my right of informed consent to such treatment. | | |
| I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment. I further authorize said center to take my child to a hospital, and I agree that I will pay all physician and hospital bills, and said center will not be responsible for them. | | |
| Signature of Parent/Guardian | | Date |
| Photograph Release | | |
| I release <i>Parkview Sonshine Academy</i> and <i>Parkview Christian Academy</i> to photograph and/or videotape my child participating in daily activities, and to use the photographs and/or videos in photographic displays or other publications showing these daily activities. | | |
| Signature of Parent/Guardian | | Date |