

THORNDALE Learning CENTER



REGISTRATION 2026-2027

Child's Name _____ Name to be used in School _____

First Middle Last

Date of Birth _____ Gender _____

Address _____

Street City Zip Code

Home Phone Number _____

Father's Name _____ Employer _____

Address (If different) _____ Work Phone # _____

_____ Cell Phone # _____

Email _____ May we Share with the Class _____

Mother's Name _____ Employer _____

Address (If Different) _____ Work Phone # _____

_____ Cell Phone # _____

Email _____ May we Share with the Class _____

Please Check Program Desired:

_____	Two-Year-Old Class: Tuesday & Thursday (9:00-12:00)	\$265 Per Month
_____	Two-Year-Old Class: Tuesday, Wednesday, Thursday (9:00-12:00)	\$290 Per Month
_____	Three's Class: Tuesday, Wednesday, Thursday	\$290 Per Month
_____	Three's Class: Monday-Thursday	\$340 Per Month
_____	3 Day Four's Class: Tuesday, Wednesday, Thursday	\$290 Per Month
_____	4 Day ½ Day PreK Class: Monday- Thursday	\$340 Per Month
_____	PreK Class: Monday- Wednesday (9:00-2:00)	\$440 Per Month
_____	PreK Class With Optional 4 th ½ day Thursday (9:00-12:00)	\$515 Per Month

(Full Day PreK is for Four- & Five-Years Olds Attending Kindergarten in the Fall of 2027)

I understand that tuition is due at the first of each month. A late fee of \$25 will be applied to all payments made after the 15th of each month. Tuition is paid one month in advance and is non-refundable without a 30 written notice of withdrawal from the school.

Please include the \$85.00 Non-Refundable Registration fee along with the Registration form to reserve the child's space.



STUDENT INFORMATION

Student Name _____ Name to Be Used in School _____

Address _____ Phone _____

Street

City

Zip

Date of Birth _____ Gender _____

Parent Emails _____

Members of the Household: Name Relationship Age

Pets: _____

School District _____ Township _____

How Did You Hear About Us? _____

Church Affiliation _____

Would you like more information about Thorndale United Methodist Church (TUMC) _____

Previous School Experience

This school _____ Other _____

Favorite Things to Do/Play _____

Any concerns or fears we should be aware of? _____

Any health concerns or allergies? _____

Any dietary restrictions? Please state the restrictions and reasons. _____

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MEDICAL INFORMATION

Student Name _____ Date of Birth _____ Gender _____

Home Phone _____ Mom's Cell _____ Dad's Cell _____

Emergency Contact Other Than Parents

Name _____ Phone # _____

Relationship to Child _____ Cell # _____

Name _____ Phone # _____

Relationship to Child _____ Cell # _____

Persons Authorized to Pick Up Child: _____

Persons NOT Authorized to Pick Up Child: _____

If we are unable to contact any of the above contacts, do we have your permission to have your child treated in case of an emergency? _____

Primary Physician _____

Physician's Phone _____

Dentist _____

Dentist Phone _____

Hospital Preference _____

Allergies _____

Dietary Restrictions and Reason _____

Medical Conditions _____

Current Medications _____

Any Condition that limits participation in certain activities _____

PLEASE ATTACH A COPY OF YOUR CHILD'S CURRENT IMMUNIZATION RECORD

Parent's Signature Date

Parent's Signature Date

Director's Signature Date

Date Rec'd Amount Check #

