



## Small Wonder Preschool

St. Mark's Catholic Church

3736 Lee's Summit Rd

Independence MO 64055

816-285-8368 - 816-373-2600

2023-2024

Website: [mysmallwonderpreschool.com](http://mysmallwonderpreschool.com)

E-mail: [smallwonderpreschool@yahoo.com](mailto:smallwonderpreschool@yahoo.com)

### ENROLLMENT INFORMATION

Please Print

#### • Child's Information:

Child's name \_\_\_\_\_ birth date \_\_\_\_\_

Boy \_\_\_\_\_ Girl \_\_\_\_\_ Name we should use at school \_\_\_\_\_

Home full address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone number you wish your child to learn: \_\_\_\_\_ Please circle: Home or Cell

Has your child had any previous children's group experience? \_\_\_\_\_

School district child will attend in kindergarten \_\_\_\_\_

Please take a moment and list some of the activities your child enjoys or other information you wish to share.

#### • Parent/Guardian Information:

Email address: \_\_\_\_\_

Child lives with: both parents \_\_\_\_\_ mother \_\_\_\_\_ father \_\_\_\_\_ guardian \_\_\_\_\_

\*Religion \_\_\_\_\_ \*Church attend \_\_\_\_\_ \*Ethnic group \_\_\_\_\_

**\* For statistical purposes only. Not used for admission.**

Father's name \_\_\_\_\_ Cell # \_\_\_\_\_

Will you be at work while your child is in preschool \_\_\_\_\_ Employer & work # \_\_\_\_\_

Mother's name \_\_\_\_\_ Cell# \_\_\_\_\_

Will you be at work while your child is in preschool \_\_\_\_\_ Employer & work # \_\_\_\_\_

Other children who are at home and age(s) \_\_\_\_\_

**Contact Information:** Please list in order the name & phone number you wish us to call:

(This information is used when a child is sick or if we need to cancel school - babysitter, grandparents, etc.)

During school hours: \_\_\_\_\_

Before School: \_\_\_\_\_

Evenings: \_\_\_\_\_

**Do you have any special talents and/or would be available to volunteer for various activities throughout the year? Specify:**

***\*To aid in the care of your child all children are accepted for a trial period of adjustment.***

2023-2024

• **Drop-Off and Pick-Up Information:**

Your child's safety is our highest priority. For that reason, we ask that you bring your child to the classroom door each morning. It is your responsibility to update the following information if changes occur. If someone other than the usual person will be picking up your child, please let the teacher know that day.

Please list all persons, other than parents, who are authorized by you to take your child from preschool.

<u>Name</u>	<u>Address</u>	<u>Phone</u>	<u>Relationship</u>
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Please list any person(s) who are **NEVER** authorized to take your child from the preschool.

<u>Name</u>	<u>Address</u>	<u>Phone</u>	<u>Relationship</u>
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Other contact information you wish to share: \_\_\_\_\_

• **Medical Information:**

Please turn in an immunization form with all immunization dates. In most cases, medication should be administered by parents at home. If your child requires any medication that must be administered at preschool, a **Medication Permission Slip** must be completed and on file. You may obtain that form in the office. Our staff will complete an Accident Form for any injury your child might receive while in our care, including injuries such as pinched fingers, and splinters, etc.

Is your child on any **regular medication**? \_\_\_\_\_ Specify: \_\_\_\_\_

**ALLERGIES?** \_\_\_\_\_

Specify any pertinent medical history we should know (**nose bleeds, speech problems**, etc)

You will be contacted in case of any emergency. If we cannot contact you, whom should we contact?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

In case of an emergency, we will make every effort to contact you. If we are unable to contact you or the person listed above, and your child requires immediate medical attention, please sign the following release to give us your permission to consult a medical provider and authorize any necessary treatment.

Should an emergency arise I \_\_\_\_\_ give my permission to Small Wonder school to consult a medical provider and authorize any necessary treatment for my

child \_\_\_\_\_. It is understood that a conscientious effort will be made to locate me or the person listed above as an emergency contact. I accept responsibility for any expenses incurred.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Child's physician: \_\_\_\_\_ phone number: \_\_\_\_\_

Hospital preference: \_\_\_\_\_ phone number: \_\_\_\_\_

• **Tuition and Registration Information:**

2023-2024

The Registration fee and September tuition must be paid at the time of enrollment in order to hold a place for your child. Tuition for October through May is due the first day of each month.

Registration fee is \$75.00 for one child or \$100.00 for two. This helps to pay for bookkeeping and classroom/office supplies used throughout the year.

Small Wonder offers several classes. Please circle the class days below that you chose for your child. If you have more than one child, a separate form is required for each. There is a \$10.00 discount for your second child's monthly tuition.

**Meet the Teacher: Thursday, August 31 — First Day of School: Tuesday, September 5, 2023**

**Pre-K Classes: Child must be 4 by July 31**

Circle Preferred Option	Days	Times	Tuition
1	Tues/Wed/Thurs	9:30-12:00 (morning class)	180/month
2	Tues/Wed/Thurs	9:30--3:00	295/month
3	Tues/Wed/Thurs	12:30-3:00 (afternoon class)	180/month
4 (offered if enough interest)	Tues/Thurs	12:30-3:00 (afternoon class)	140/month

**Preschool Classes: Child must be 3 by July 31**

Circle Preferred Option	Days	Times	Tuition
1	Tues/Wed/Thurs	9:30-12:00	180/month
2 (offered if enough interest)	Tues/Thurs	9:30-12:00	140/month

**Early Learners: Child must be 2 by July 31**

1	Tues/Thurs	9:30-12:00	140/month
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**Stay-n-Play: Available 9:30-3:00. Paid as an hourly rate**

Each month may have a different number of days that the children are present for class. The tuition is the same each month and the days average out through the year.

I have enrolled \_\_\_\_\_ child/children in Small Wonder Preschool.

I have paid the registration fee of \$ \_\_\_\_\_ Check # or cash \_\_\_\_\_ Date Paid: \_\_\_\_\_

I have paid September tuition of \$ \_\_\_\_\_ Check # or cash \_\_\_\_\_ Date Paid: \_\_\_\_\_

**GENERAL INFORMATION:**

Our Get-Acquainted Meeting Day is Thursday, August 31. (School will start the next Tuesday, September. 5)  
 You will receive a post card mid-August with the time reserved for you to meet the teacher. You do not need to bring supplies; we will purchase all needed supplies. Throughout the year you may be asked to provide snacks or occasional items for special projects.

All new students are required by the Health Department to complete an immunization form for our files.

All returning students must keep our immunization records updated.

This is a requirement to attend preschool and must be turned in before the 1st day of school.

- **Picture Release - 2023/2024**

The teachers and staff at Small Wonder Preschool frequently take pictures of the children during play and work at school. These pictures will be displayed in the school hallway and also on our website.

\_\_\_\_\_ I hereby grant permission for my student to be included in photographs, videos and other recordings made in connection with St. Mark's Small Wonder Preschool and /or the Catholic Diocese of Kansas City-St. Joseph for a period of one calendar year. I have read, understand and agree to the above statement.

Parent(s) Signature \_\_\_\_\_ Date: \_\_\_\_\_

- **Small Wonder Permission Form - 2023 / 2024**

We may take field trips throughout the school year. Sometimes we will take a bus and sometimes a parent will be asked to drive. You will always be notified and reminded before the trip. So that your child may take part in the field trips, please fill in the following:

I, we, the parent(s) of \_\_\_\_\_ request that our child be allowed to participate in Small Wonder Preschool's field trips. In consideration for the making of arrangements of these trips, I hereby release and save harmless St. Mark's Parish and any and all employees and volunteers from any and all liability for any and all injury resulting from these trips.

Parent(s) Signature \_\_\_\_\_ Date: \_\_\_\_\_

- **Marketing Information**

Please circle how you heard of Small Wonder:

Word of Mouth - Outdoor Sign - Bulletin Notice - Website -

Family Member Previously Enrolled - Other \_\_\_\_\_



*Welcome to our school!*



RESET

CHILD'S NAME	BIRTHDATE

*(Date of medical examination must be within the last 12 months.)*

## This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

DATE

TELEPHONE NUMBER

The Department of Elementary and Secondary Education does not discriminate on the basis of race, color, religion, gender, gender identity, sexual orientation, national origin, age, veteran status, mental or physical disability, or any other basis prohibited by statute in its programs and activities. Inquiries related to department programs and to the location of services, activities, and facilities that are accessible by persons with disabilities may be directed to the Jefferson State Office Building, Director of Civil Rights Compliance and MOA Coordinator (Title VI/Title VII/Title IX/504/ADA/ADAAA/Age Act/GINA/USDA Title VI), 5th Floor, 205 Jefferson Street, P.O. Box 480, Jefferson City, MO 65102-0480; telephone number 573-526-4757 or TTY 800-735-2966; email [civilrights@dese.mo.gov](mailto:civilrights@dese.mo.gov).

Thank you!

## OFFICIAL DOCUMENT

NAME	
DATE OF BIRTH	DCN (Department Client Number)
NAME OF PARENTS OR LEGAL GUARDIAN	
ADDRESS	

The immunization record plays a vital role in protecting the health of the individual throughout life, for health care providers, school, day care, employers.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER  
Services provided on a nondiscriminatory basis.

If you desire a copy of this publication in an alternate form because of a disability, contact the Department of Health and Senior Services' immunization program at 800-699-2313. Hearing-impaired citizens may contact the department by phone through Missouri Relay, 800-735-2966.

ALLERGIES/COMMENTS/VACCINE REACTIONS

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

VACCINE	DATE GIVEN MO/DAY/YR		PHYSICIAN/CLINIC	
PNEUMOCOCCAL POLYSACCHARIDE (23 valent)				
INFLUENZA (annual) List mo/day/yr of each vaccine				

DATE GIVEN MO/DAY/YR	DATE READ MO/DAY/YR	PHYSICIAN/NURSE SIGNATURE	RESULTS
			mm
			mm
			mm

LEVEL	DATE	LEVEL	DATE	LEVEL	DATE

VACCINE	DATE GIVEN MO/DAY/YR	PHYSICIAN/CLINIC
<b>DTaP, DTP, or DT</b>	1	
Diphtheria,	2	
Tetanus, Pertussis	3	
(Whooping	4	
Cough)	5	
specify if DT		
<b>POLIO</b>	1	
Specify	2	
IPV or OPV	3	
	4	
<b>HAEMOPHILUS</b>	1	
<b>INFLUENZAE</b>	2	
type b (Hib)	3	
	4	
<b>HBIG</b>		
<b>HEPATITIS B</b>	1	adult / ped
circle type	2	adult / ped
	3	adult / ped
	4	adult / ped
<b>PNEUMOCOCCAL</b>	1	
<b>CONJUGATE</b>	2	
	3	
	4	
<b>MMR</b>	1	
	2	
<b>VARICELLA</b>	1	
(Chickenpox)	2	
<b>HEPATITIS A</b>		
<b>Tdap/Td</b>		
Tetanus, Pertussis,		
Diphtheria		
Adult		
(every 10 yrs)		
<b>Meningococcal</b>		
<b>Rotavirus</b>	1	
	2	
	3	
<b>HPV</b>	1	
Human	2	
Papillomavirus	3	
<b>OTHER</b>		