

ST. FRANCES CABRINI PRESCHOOL

Mary, Queen of Saints Parish

2026-2027

OPTION 1

\$ 1,600.00 yearly

(Cash/Check)

Due September 2026

4/5 PROGRAM

OPTION 2

\$178.00 monthly

(Cash /Check)

Due 1st class of each month

Child's Last Name: _____ First Name: _____ Middle: _____

Name called by: _____ Date of Birth: ____/____/____ Age: _____ Sex: ____M ____F

Mother's Name: _____ Maiden Name: _____

Home Phone: _____ Cell Phone: _____ email: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____

Father's Name: _____

Home Phone: _____ Cell Phone: _____ email: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____

Who is legal guardian of the above child? _____ Both Parents _____ Mother only OR _____ Father only

Home School District: _____

Is your child predominately _____ right handed? _____ left handed? _____ undecided

Is your child receiving _____ speech therapy? _____ occupational therapy? _____ other?

Please PLACE A CHECK MARK where you will allow photographing your child.

May we photograph your child while in our care for our use only?

_____ Social Media (Preschool Facebook/Instagram page) _____ Parish Website _____ Church Bulletin

_____ Bulletin board, cards, crafts

Mother Catholic? ____ Yes ____ No (if yes) Name of parish _____ No parish _____

Father Catholic? ____ Yes ____ No (if yes) Name of Parish _____ No parish _____

Neither parent Catholic _____

We need this information for a DIOCESAN STATISTICAL REPORT...PLEASE COMPLETE THIS SECTION

(We) (I) pledge cooperation with St. Frances Cabrini Preschool Center in encouraging my(our) child to follow its instructions, in upholding the authority of the teachers in matters of discipline, and in assuming the responsibility of paying financial obligations as above acknowledged. (We) (I) also assume the responsibility to pay the FULL tuition regardless of the number of days (our) (my) child is in attendance during the school year.

Signature of Parent (guardian) completing this form.

_____ Date _____

FOR SCHOOL USE

\$50.00 NON REFUNDABLE REGISTRATION FEE _____ CHECK # or CASH _____

Birth certificate: state of _____ Immunization record _____ YES _____ NO

TURN OVER AND FILL IN THE BACK SIDE OF THIS FORM

ST. FRANCES CABRINI PRESCHOOL MEDICAL EMERGENCY CONSENT – 2025-2026

Name of Child: _____
(Last Name) (First Name)

Name of Child's Doctor: _____ Phone Number of Doctor: _____

Medical Insurance Company: _____ Policy Number: _____

Child's Hospital: _____ Phone Number of Hospital: _____

KNOWN MEDICAL ALLERGIES

KNOWN FOOD ALLERGIES

Parents Signature is required at the bottom of this page to indicate Parental Consent

Initials here _____ For Emergency Medical Care.

Initials here _____ For Minor First Aid Procedures.

When there is a medical emergency, or when a child needs immediate medical treatment, St. Frances Cabrini Preschool will take all reasonable steps to see that the children in their care receive adequate medical care. When appropriate the preschool will call 911 and the parents. If the parents cannot be reached, the preschool will call the persons listed below who are authorized by the parent to give permission for the medical treatment of the child.

These persons authorized to do so are:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

If the parents and the authorized persons cannot be reached the preschool will call the child's doctor, identified above. If the child must be taken to the hospital, the preschool will take the child to the child's hospital identified above. If under the circumstances it is more reasonable to bring the child to another hospital, the preschool will do so. In the situation where the person and the persons authorized to give permission for medical treatment cannot be reached: the parent authorizes the child's doctor to provide the appropriate medical treatment for the child.

Signature of Parent (guardian) completing this form.
