St. James Early Learning Center

2018-2019

Student Application

The stronger the start, the better the finish.

PARENTS, PLEASE FILL OUT ALL SECTIONS COMPLETELY.

Class: ____ 1's ____ 2's ____ 3's (*Must meet age requirement Sept. 1, 2018)*

Program: ____ Day School (7:00-3:30) OR ____ Extended Day School (7:00-6:00)

Days: ____ 2 days week (t-th) ____ 3 days week (m-w-f) ____ 5 days week (m-f)

Student Name ____ ________________

Last First Middle Name Used

Address ____

City ______________________________________ State____________ Zip______________

Age __________ years ________months Birth Date______________________ O Male O Female

Primary language spoken at home: ____

Parent Name	**Parent Name**
City State Zip	City State Zip
Telephone Cell Phone	Telephone Cell Phone
Occupation	**Occupation**
Business Address	Business Address
City State Zip	City State Zip
Business Phone	Business Phone

Are both parents living at same address? O Yes O No

PRIMARY EMAIL ADDRESS ____

PRIMARY PHONE NUMBER ____

May we share your primary email and primary phone number with other parents enrolled at SJELC? ___Y ___N

How are you connected to St. James ELC? (Please check off all that apply)

___Returning ELC Family ___SJELC Sibling ___St. James Parishioner ___St. James School Family ___Alumni ___New Family

Are you a St. James Parish member? ____ Yes ____ No Envelope No. _____________ Preferred Mass Time _______________

Present School or Childcare ____

Over

Student Information

Does your child have a medical or physical condition that may limit their participation in our program? O Yes O No

Does your child have any allergies? O Yes O No Please list and describe below.

____

____

Is there any pertinent information that will help us understand and plan for your child? O Yes O No

If yes, please explain.

____

____

Emergency Contacts

____

Name Relationship to child Telephone

____

Name Relationship to child Telephone

PEDIATRICIAN NAME_________________________________ **PHONE**____________________________

DENTIST NAME_____________________________________ **PHONE**____________________________

People I/We authorize to pick up my/our child.

____

Name Relationship to child Telephone

____

Name Relationship to child Telephone

I/We DO NOT AUTHORIZE the person listed below to pick up my/our child. (SUBMIT IN WRITING, COURT DOCS, WITH PHOTO)

____

Name Relationship to child Telephone

Applicants to the St. James Early Learning Center (SJELC) are considered for admission based on available space and our ability to serve your child. Priority for available space is granted in the following order: current SJELC families and siblings, St. James Parish member families, St. James School Families, Participating Catholics, and Full-time over Part-Time. The school does not discriminate because of race, color, national origin, sex, gender, religion, or any other category protected by law.

Your signature below indicates that all information contained in this application is complete and factually correct. In addition, I understand that it is my responsibility to maintain updated information to the school. I understand that the enclosed registration fee of $150. is required to complete this application.

______________________ ______________________ ______________

Signature Name (Printed) Date

______________________ ______________________ ______________

Signature Name (Printed) Date

For Office Use Only:

Date Application Received at SJELC:_______________Time Application received at SJELC:__________ Room:_________ Start Date:___________

Priority: O Current ELC Family/Sibling O St. James Parish Family O St. James School Family O Participating Catholics O Full Time over Part Time

O Registration Fee Paid - Check No.________________ O Supply Fee Paid - Check No:________________ O Shot Record Rec'd

St. James Early Learning Center

8412 Whitefield Avenue Savannah, GA 31406
912-355-1523(office) 912-629-2430(center)

EMERGENCY MEDICAL CARE AUTHORIZATION
2018-19 SCHOOL YEAR

Should my child, ______________________________, ______________________
(Child's Name) (Child's Date of Birth)
suffer an injury or illness while in the care of St. James Early Learning Center, and the facility is unable to contact me(us) immediately, it shall be authorized to secure medical attention and care for the child as deemed necessary. I (We) shall assume responsibility for payment of services.

PARENT/GUARDIAN

____
PRINT NAME

____
SIGNATURE

____
DATE

PARENT/GUARDIAN

____
PRINT NAME

____
SIGNATURE

____
DATE

ELC DIRECTOR OR PERSON-IN-CHARGE ONLY:

____
PRINT NAME

____
SIGNATURE

____
DATE