



# Preschool Registration Packet 2018/2019 School Year

Circle One: Returning Student / New Student

Child's Name: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

## Circle selected class

### Preschool Explorers (Ages 3-4)

Day	Date	Time	Teacher
TU/TH	9/4-5/16	9:00 am - 11:15 am	
TU/TH	9/4-5/16	9:30 am - 11:45 am	
TU/TH	9/4-5/16	9:30 am - 11:45 am	
TU/TH	9/4-5/16	1:15 pm - 3:30 pm	

### Preschool Adventurers (Ages 4-5)

Day	Date	Time	Teacher
M/W/F	9/5-5/17	9:00 am - 11:15 am	
M/W/F	9/5-5/17	9:30 am - 11:45 am	
M/W/F	9/5-5/17	9:30 am - 11:45 am	
M/W/F	9/5-5/17	1:15 pm - 3:30 pm	

### Preschool Adventurers (Ages 4-5) *For children who start kindergarten in the fall of 2019.*

Day	Date	Time	Teacher
M-F	9/5-5/17	9:00 am-11:15 am	

### If you are not paying in full for the entire 2018/2019 preschool year, the following rules apply:

- A parent or guardian must sign the Payment Schedule Contract and hand in at the time of registration.
- Payments are due on the first of each month (September through April). Last payment will be due on April 1<sup>st</sup>.
- Payments will be automatically charged to your credit/debit card on the 1<sup>st</sup> of each month.
- If credit/debit is declined, a \$25.00 fee will be charged to your account.
- Your credit card number and signature must remain on file with the Village of Glendale Heights Sports Hub.
- If your child is no longer going to attend preschool, the preschool program cancellation form must be received by the 20th of the month before. If we are not notified, your credit/debit card will be charged the installment bill payment amount and will not be refunded.

### The Village of Glendale Heights will automatically charge your credit/debit card on the 1<sup>st</sup> of each month.

I, \_\_\_\_\_ authorize the Village of Glendale Heights to automatically charge my credit card on the 1<sup>st</sup> of each month (September through April) for payment of my preschool account. The amount that will be charged each month is the amount agreed on the payment schedule.

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

**PATH** After School Program is now available to Glendale Heights Preschool students attending Kindergarten in the Fall of 2019. See a Customer Service Associate for more information.



# Glendale Heights Preschool Payment Plan Agreement

Child's Name: \_\_\_\_\_ Parent's Name: \_\_\_\_\_

A payment plan is offered to assist parents with the financial responsibilities of the Glendale Heights Preschool Program. The total registration fee is divided into 9 equal payments (installment bills). Installment bill payments are due on the following dates: First payment due at the time of registration: September 1, 2018: October 1, 2018: November 1, 2018: December 1, 2018: January 1, 2019: February 1, 2019: March 1, 2019 and April 1, 2019.  
**A \$25.00 fee will be charged to your account if credit/debit card is declined.**

Circle selected class	Total Program Fee (32 week session)	Registration Fee	Supply Fee	Due at Registration (before 9/1/18)	Due at Registration (9/1/18 or later)	Installment Bill
Preschool Explorers (2 days)	\$828/\$918/\$1008	\$30	\$30	\$152/\$162/\$172	\$244/\$264/\$284	\$92/\$102/\$112
Pre-K Adventurers (3 days)	\$1233/\$1323/\$1413	\$30	\$30	\$197/\$207/\$217	\$334/\$354/\$374	\$137/\$147/\$157
Pre-K Adventurers (5 days)	\$1764/\$1854/\$1944	\$30	\$30	\$256/\$266/\$276	\$452/\$472/\$492	\$196/\$206/\$216

The first payment is due at the time of registration along with the \$30 registration fee and \$30 supply fee. The registration fee and supply fee is non-refundable.

I, the undersigned parent or guardian of the aforementioned child, now register said child to the Glendale Heights Parks & Recreation Department's Preschool program for the upcoming 32 week session. In doing so, I fully understand that I am committed to pay the entire fee regardless of child's attendance.

**REQUIRED: (The information below must be complete at time of registration)**

I, \_\_\_\_\_ parent or guardian of (please list all children enrolled)

\_\_\_\_\_ agree to the terms listed above.

Visa      Mastercard      Discover      (please circle one)

Credit Card # (last four digits only) \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

I, \_\_\_\_\_ authorize the Village of Glendale Heights to automatically charge my credit card on the above dates for the Glendale Heights Preschool Program.

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

**Cancellation Policy**

If your child is no longer going to attend preschool, the preschool program cancellation form must be received by the 20<sup>th</sup> of the month before. If we are not notified, your credit/debit card will be charged the installment bill payment amount and will not be refunded.

# GLENDALE HEIGHTS PRESCHOOL ADMISSION FORM

**Office Use Only**

Child's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Sex: M F

Place of Birth: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Father Name: \_\_\_\_\_

Father/Guardian Address & Phone Number (if different than child's):

\_\_\_\_\_ Phone: \_\_\_\_\_

Father/Guardian Occupation: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father/Guardian Business Address: \_\_\_\_\_

Father/Guardian Working Hours: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_

Mother/Guardian Name: \_\_\_\_\_

Mother/Guardian Address & Phone Number (if different than child's):

\_\_\_\_\_ Phone: \_\_\_\_\_

Mother/Guardian Occupation: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mother/Guardian Business Address: \_\_\_\_\_

Mother/Guardian Working Hours: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_

Marital Status of Parents: \_\_\_\_\_ Years Married: \_\_\_\_\_

Enrollment Date: \_\_\_\_\_

Discharge Date: \_\_\_\_\_

M/W/F AM Class: \_\_\_\_\_

M/W/F PM Class: \_\_\_\_\_

M-F AM Class: \_\_\_\_\_

M-F PM Class: \_\_\_\_\_

TU/TH AM Class: \_\_\_\_\_

TU/TH PM Class: \_\_\_\_\_

Teacher Request \_\_\_\_\_

Returning Student  New Student

Person(s) to whom the child may be released and notified in an emergency, when the parent is unavailable. (If there are any changes, please advise the teacher with a note or verbally) PLEASE NOTE: If there are any special instructions, or any person(s) who are never to be authorized to pick up your child, please notify your child's teacher.

NAME	ADDRESS	PHONE NUMBER
_____	_____	_____
_____	_____	_____

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

If none of the above person(s) can be contacted during an emergency, do you give the school and/or your physician the authority to administer first aid if necessary in the best interest of the child?

\_\_\_\_\_

# PRESCHOOL ADMISSION FORM

CHILD'S NAME: \_\_\_\_\_ NICKNAME: \_\_\_\_\_

## BROTHERS & SISTERS:

NAME	DATE OF BIRTH	SCHOOL
_____	_____	_____
_____	_____	_____
_____	_____	_____

May the school use photographs of your child, taken during school hours for publicity purposes (names will not be used with photo)? Yes \_\_\_ No \_\_\_

Do you agree to hold the Glendale Heights Recreation Department, it's employees and the school, the facility in which it is held, and your physician free and to indemnify the aforementioned against claims and demands made on behalf of the child named above? Yes \_\_\_ No \_\_\_

Does the teacher have your permission to take your child along with the rest of the class, under her care, on walks in the general area of the school, for the purpose of nature walks, etc.? Yes \_\_\_ No \_\_\_

The school retains the right to dismiss from the group and to retain the full registration fee on any child, who after a reasonable trial, demonstrates the inability to participate in or benefit from the school, or whose presence is detrimental to the group.

Is your child: Right Handed \_\_\_\_\_ Left Handed \_\_\_\_\_

Are there significant personal characteristics of the child, such as; physical, emotional, or mental handicaps that require special handling at this time? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Does your child have any fears that the teacher should be aware of? \_\_\_\_\_

If so, please explain: \_\_\_\_\_

Is your child currently taking any medication? \_\_\_\_\_ If so please explain \_\_\_\_\_

\_\_\_\_\_

Does your child have any allergies of any nature? \_\_\_\_\_ If so, please list \_\_\_\_\_

\_\_\_\_\_

Does your child have any food restrictions? \_\_\_\_\_ If so, please list \_\_\_\_\_

\_\_\_\_\_

# PRESCHOOL ADMISSION FORM

**CHILD'S NAME:** \_\_\_\_\_

What school or other group experience has your child had previously?

\_\_\_\_\_

What does your child say when they need to go to the bathroom?

Is English a second language? Yes \_\_\_ No \_\_\_

Is English spoken at home? Yes \_\_\_ No \_\_\_

How do you feel that your child usually reacts to new situations?

\_\_\_\_\_

\_\_\_\_\_

Is there anything else you feel we should know about your child?

\_\_\_\_\_

\_\_\_\_\_

To comply with the licensing requirements, and for the proper functioning of the school, it is understood that every child accepted in this school will be required to have taken a physical examination. Likewise each child must have a signed "Emergency Care/First Aid Consent Form", (please see attached) prior to the first day of school.

Your signature below indicates that the answers on this application are truthful and that the parent or guardian understands and agrees to comply with the requirements and restrictions outlined or explained on this form.

**SIGNATURE OF PARENT/GUARDIAN:** \_\_\_\_\_

**DATE SIGNED:** \_\_\_\_\_

# **PRESCHOOL ADMISSION FORM**

## **EMERGENCY CARE / FIRST AID CONSENT FORM**

CHILD'S NAME: \_\_\_\_\_

In case of sickness or accident of my child, while under the care and supervision of the Glendale Heights Recreation Department, I the undersigned, give my permission/consent to the Glendale Heights Recreation Department Preschool employees, to provide emergency First Aid and/or treatment through a clinic, a hospital, or provide a doctor. I give my express consent for X-Rays if the doctor or hospital feels it is advisable or necessary. I also agree to pay all costs and fees contingent upon any emergency medical care and/or treatment for my child as secured or authorized under this consent. This agreement shall continue as long as the above mentioned child is enrolled in the Glendale Heights Recreation Department Preschool Program.

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_

DATE SIGNED: \_\_\_\_\_

## **PRESCHOOL CARPOOL INFORMATION SHEET**

CHILD'S NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

PHONE: \_\_\_\_\_

I AM IN A CAR POOL: YES \_\_\_\_\_ NO \_\_\_\_\_

### **MY CHILD MAY BE RELEASED TO THE FOLLOWING DRIVERS IN THE CAR POOL:**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

-

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

-

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

-

### **TRANSPORTATION IS THE RESPONSIBILITY OF THE PARENTS!!!**

Parents must form their own car pools, or provide their own transportation to and from the preschool.

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

ADDITIONAL INFORMATION: \_\_\_\_\_

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### **PERMISSION FOR LOCAL FIELD TRIPS**

During the school year, the teacher and aide will occasionally take the children on local field trips. These trips will consist of a walk in the neighborhood to increase awareness of the environment, and to collect miscellaneous treasures, such as: fallen leaves, pine cones, etc. I grant my permission for my child to attend these local trips with his/her class.

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_



## **Late Pick Up Policy**

As required by Illinois Department of Children and Family Services

It is the ***utmost importance*** that the preschool staff have current information for parents and emergency contacts on file.

Please keep the staff informed of any changes.

If a parent fails, without notice to pick up a child at the time class is to end, or to arrange to have someone else pick up, the preschool staff will make 3 attempts to contact the parents.

If the staff is unable to reach the parent at home, cell or work numbers, emergency contacts will be called.

If, after one hour, the Preschool staff is unable to locate a parent or emergency contacts, staff will contact the Glendale Heights Police Department for assistance in locating the parents.

A Village of Glendale Heights employee will stay with the child until parents/emergency contacts or police arrive. Any discussion regarding late pick up will occur between parents and staff. Children will not be held accountable for late pick up occurrences.

**Parents that are more than 10 minutes late will  
be fined \$5.00 per 10 minutes.**

In complying with licensing standards from the Illinois Department of Children and Family Services, we are asking that you review and sign this Late Pick Up Policy.

\_\_\_\_\_  
*Child's Name*

\_\_\_\_\_  
*Parents Signature*

\_\_\_\_\_  
*Date*





## Guidance and Discipline Policy

The Glendale Heights Preschool staff will work to provide a positive supportive environment which attempts to enhance children's self-esteem and teach them how to make good choices. Unacceptable behavior in the classroom results in the teacher redirecting the child's activity toward a positive direction. All staff will help children develop self-control and encourage them to take responsibility for their own actions. Teachers and parents are encouraged to be in close communication when there is a need to problem solve.

Staff will use firm, positive statements when redirecting a child from unacceptable behavior to a more positive one. Children who do not respond to direction may be removed from the group to help gain control. This removal time shall not exceed one minute per age of the child.

If a behavior is beyond the scope of stated classroom rules interferes significantly with the learning environment safety of the children, then the parents, teachers and supervisor will discuss further action to be taken to ensure the safety and well being of all children involved.

\_\_\_\_\_  
*Child's Name*

\_\_\_\_\_  
*Parents Signature*

\_\_\_\_\_  
*Date*



Please Print

<b>Student's Name</b>				<b>Birth Date</b>			<b>Sex</b>	<b>Grade Level</b>			<b>ID #</b>
Address code		Street	City	ZIP	Parent/ Guardian			Telephone # Home:			Work

**IMMUNIZATIONS:** To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

VACCINE/DOSE	1			2			3			4			5			6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
Diphtheria, Tetanus and Pertussis (DTP or DTaP)																		
Diphtheria and Tetanus (Pediatric DT or Td)																		
Inactivated Polio (IPV)																		
Oral Polio (OPV)																		
Haemophilus influenzae type b (Hib)																		
Hepatitis B (HB)																		
Varicella (Chickenpox)																		Comments:
Combined Measles, Mumps and Rubella (MMR)																		
Measles (Rubeola)																		
Rubella (3-day measles)																		
Mumps																		
Pneumococcal (not required for school entry)	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23		<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23		<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23		<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23		<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23		<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	
Check specific type (PCV7, PPV23)      Date																		
Other (Specify: Hepatitis A, meningococcal, etc.)																		

**Health care provider (MD, APN, PA, school health professional, health official) verifying above immunization history must sign below.**

<b>Signature</b>	<b>Title</b>	<b>Date</b>
<b>Signature</b>	<b>Title</b>	<b>Date</b>
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.)		
<b>Signature</b>	<b>Title</b>	<b>Date</b>
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.)		

**ALTERNATIVE PROOF OF IMMUNITY**

1. Clinical diagnosis is acceptable if verified by physician \* (All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

\*MEASLES (Rubeola)    MO    DA    YR    MUMPS    MO    DA    YR    VARICELLA    MO    DA    YR    Physician's Signature

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.  
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.  
Date of Disease: \_\_\_\_\_  
Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

3. Laboratory confirmation (check one)    Measles    Mumps    Rubella    Hepatitis B    Varicella

Lab Results \_\_\_\_\_ Date \_\_\_\_\_ MO    DA    YR    ( Attach copy of lab report, if available.)

VISION AND HEARING SCREENING DATA														
This section to be completed by IDPH certified screening personnel, if pre-existing approved IDPH form is not available. Pre-school - annually beginning at age 3; School age - during school year at required grade levels.														
Date														
Age/Grade	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Vision														
Hearing														

Code:  
P = Pass  
F = Fail  
U = Unable to test  
R = Referred  
G/C=Glasses/  
Contacts

Printed by Authority of the State of Illinois (over)

Student's <b>Name</b> Last First Middle	<b>Birth</b> <b>Date</b> Month Day Year	Sex	School	Grade Level/ ID #
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**HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

	Circle one	Comments		Circle one	Comments
Diagnosis of Asthma? Wheeze/Cough During or After Play?	Yes <input type="radio"/> No <input type="radio"/>	Indicate Severity:	Loss of Function of One of Paired Organs? (Eye/Ear/Kidney/Testicle)	Yes <input type="radio"/> No <input type="radio"/>	
Birth Defects?	Yes <input type="radio"/> No <input type="radio"/>		Hospitalizations? When? What for?	Yes <input type="radio"/> No <input type="radio"/>	
Developmental Delay?	Yes <input type="radio"/> No <input type="radio"/>				
Blood Disorders? Hemophilia, Sickle Cell, Other? Explain	Yes <input type="radio"/> No <input type="radio"/>		Surgery? (List All) When? What For?	Yes <input type="radio"/> No <input type="radio"/>	
Diabetes?	Yes <input type="radio"/> No <input type="radio"/>		Serious Injury or Illness?	Yes <input type="radio"/> No <input type="radio"/>	
Head Injury/Concussion/Passed Out?	Yes <input type="radio"/> No <input type="radio"/>		TB Skin Test Positive (Past or Present)?	Yes* <input type="radio"/> No <input type="radio"/>	* Refer positive response to the local health department.
Seizures? What are they like?	Yes <input type="radio"/> No <input type="radio"/>		TB Disease (Past or Present)?	Yes* <input type="radio"/> No <input type="radio"/>	
Heart Problem/Shortness of Breath?	Yes <input type="radio"/> No <input type="radio"/>		Tobacco Use (Type, Frequency)?	Yes <input type="radio"/> No <input type="radio"/>	
Heart Murmur/High Blood Pressure?	Yes <input type="radio"/> No <input type="radio"/>		Alcohol/Drug Use?	Yes <input type="radio"/> No <input type="radio"/>	
Dizziness or Chest Pain With Exercise?	Yes <input type="radio"/> No <input type="radio"/>		Family History of Sudden Death Before Age 50? (Cause?)	Yes <input type="radio"/> No <input type="radio"/>	
Bone/Joint Problems/Injury? Scoliosis?	Yes <input type="radio"/> No <input type="radio"/>		Dental • Braces • Bridge • Plate Other		
Ear/Hearing Problems?	Yes <input type="radio"/> No <input type="radio"/>		Other Concerns?		
Eye/Vision Problems? Glasses Contacts Last Exam _____ Other Concerns?			<b>Information on this form may be shared with appropriate personnel for health and educational purposes.</b>		
			<b>Parent/Guardian Signature</b>		<b>Date</b>

**TO BE COMPLETED BY MD/APN/PA (\* INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES OR SELECTED SCHOOLS AND PROGRAMS)**

Strongly Recommended Tests	Date	Results	Date	Results
Hemoglobin * or			Urinalysis	
Hematocrit *			Sickle Cell * (as needed)	

**Lead Questionnaire\*** Completed? Yes  No  Date \_\_\_\_\_ Blood Test Indicated? Yes  No  Blood Test Performed? Yes  No

**TB Skin Test** Recommended only for children in high-risk groups: includes children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. **Date Read** / / **Result** mm

PHYSICAL EXAMINATION REQUIREMENTS		HEIGHT	WEIGHT	B/P	HEART RATE
	Normal			Normal	
		Comments/Follow-up/Needs			
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes			Genito-Urinary		LMP
Nose			Neurological		
Throat			Musculoskeletal		
Mouth/Dental			Spinal Examination		
Cardiovascular/HTN			Nutritional Status		
Respiratory			Mental Health		

ALLERGIES (Food, drug, insect, other)	MEDICATION (List all prescribed or taken on a regular basis.)
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NEEDS/MODIFICATIONS required in the school setting	DIETARY Needs/Restrictions
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**SPECIAL INSTRUCTIONS/DEVICES** e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic supporter/cup

**MENTAL HEALTH/OTHER:** Is there anything else that you think the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: • Nurse • Teacher • Counselor • Principal

**EMERGENCY ACTION** needed while at school due to child's health condition (e.g. seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

Yes  No  If yes, please describe:

On the basis of the examination on this day, I approve this child's participation in: (If No or Modified, please attach explanation.)

PHYSICAL EDUCATION Yes  No  Modified  INTERSCHOLASTIC SPORTS (for one year) Yes  No  Limited

Physician/Advanced Practice Nurse/Physician Assistant performing examination

Print Name Signature Date

Address Phone

# Please Keep this Copy For Your Records



## Glendale Heights Preschool Payment Plan Agreement

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