

# **CHRIST LUTHERAN EARLY EDUCATION CENTER**

11720 Nieman Road, Overland Park, KS 66210



**APPLICATION FOR ENROLLMENT  
2025-2026**

# CHRIST LUTHERAN EARLY EDUCATION CENTER APPLICATION FOR ENROLLMENT 2025-2026

Age	Full day
3	<input type="checkbox"/>
4	<input type="checkbox"/>
Pre-K	<input type="checkbox"/>

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Parent's Day Out:** 2 ½ - 3 ½ year old      9:00-11:30am Half Day      9:00-2:30pm Full Day

**Monday**       Half Day       Full Day      **Tuesday**       Half Day       Full Day

**Wednesday**       Half Day       Full Day      **Thursday**       Half Day       Full Day

**\*Friday**       Half Day      *\*If there is enough interest.*

**Preschool:** Students who are 3 or 4 by September 1<sup>st</sup>      9:00-11:30am

*Students must be reliably potty trained and able to use the bathroom independently.*       Yes       No

3 Year Old **Monday & Wednesday** Class

3 Year Old **Tuesday & Thursday** Class

4 Year Old **Monday-Wednesday-Friday** Class

4 Year Old **Tuesday-Thursday-Friday** Class

**Pre-K:** 5 years old by October 31<sup>st</sup>      9:00-11:30am (must attend all four days)

**Monday, Tuesday, Wednesday, Thursday**

**Friday Discovery:** 9:00-11:30am

**Friday**

**Multi-age Class (3's, 4's & 5's):** Flexible scheduling options, M-F, 8:30am – 3:30pm

My child is reliably potty trained and able to use the bathroom independently.       Yes       No

	<input type="checkbox"/> <b>Monday</b>	<input type="checkbox"/> <b>Tuesday</b>	<input type="checkbox"/> <b>Wednesday</b>	<input type="checkbox"/> <b>Thursday</b>	<input type="checkbox"/> <b>Friday</b>
<b>Before Care</b>	__ 8:30-9:00	__ 8:30-9:00	__ 8:30-9:00	__ 8:30-9:00	__ 8:30-9:00
<b>Class</b>	__ 9:00-11:30	__ 9:00-11:30	__ 9:00-11:30	__ 9:00-11:30	__ 9:00-11:30
<b>Lunch Bunch</b>	__ 11:30-2:30	__ 11:30-2:30	__ 11:30-2:30	__ 11:30-2:30	__ 11:30-2:30
<b>Full Day</b>	__ 8:30-3:30	__ 8:30-3:30	__ 8:30-3:30	__ 8:30-3:30	__ 8:30-3:30

**Extended Day Options:**

**Before Care:** 8:30-9:00 am       Monday       Tuesday       Wednesday       Thursday       Friday

**Lunch Bunch:** 11:30am-2:30pm       Monday       Tuesday       Wednesday       Thursday       Friday

## STUDENT INFORMATION

Student's Legal Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Boy  Girl Birth Date: \_\_/\_\_/\_\_\_\_ Home Phone: \_\_\_\_\_

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

City & State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary email address to use for correspondences: \_\_\_\_\_

Church child attends: \_\_\_\_\_ Baptized:  Yes  No

Would you like a pastor to contact you?  Yes  No

### Mother/Guardian

Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

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

City & State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Church Affiliation: \_\_\_\_\_

### Father/Guardian

Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

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

City & State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Church Affiliation: \_\_\_\_\_

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## STUDENT INFORMATION continued

Does student live with both parents? (Please check one.)  Yes  No

If no, please provide the following information on the non-custodial parent:

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

Relationship to student: \_\_\_\_\_

Address: \_\_\_\_\_ City/State \_\_\_\_\_

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

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

Does the non-custodial parent have permission to pick up the student? YES NO

If no, please complete the following Explanation of Custodial Arrangement: (Attach a copy of the court order specifying restrictions) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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## SOCIAL HISTORY

Siblings:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Tell us how your child interacts with parents, siblings and/or other members in the household:

\_\_\_\_\_  
\_\_\_\_\_

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## SOCIAL HISTORY continued

Other children in the neighborhood? \_\_\_\_\_

Has child received extensive care by someone other than parents? \_\_\_\_\_

By whom? \_\_\_\_\_ In own home or outside home? \_\_\_\_\_

Has child had group-play experiences such Story Time, MOPS, or Sunday School, etc.? \_\_\_\_\_

Special remarks concerning the child: (example: challenges, needs or fears) \_\_\_\_\_

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## CONTACTS

Person(s) **other than** parents authorized to take your child from school\*:

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City & State \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City & State \_\_\_\_\_

\*Both parents will be assumed to have permission to take the child unless written revocation is submitted.

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## HEALTH INFORMATION

Any concerns for possible delays in speech, motor skills, hearing, vision or other physical limitations? \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

Has the student ever been screened or identified for special services (speech/language, sensory, occupational therapy)? \_\_\_\_\_ If so, please explain \_\_\_\_\_

Is your child receiving any services through an outside agency? \_\_\_\_\_

Any allergies, asthma, or other health concerns? If so, please list and explain procedure for care: \_\_\_\_\_

List medication(s) taken regularly: \_\_\_\_\_

*(Note: proper physician permission forms must be on file if medication is to be administered during school day.)*

List previous hospitalizations or surgery: \_\_\_\_\_

Does the student have or had he/she had the following medical problem(s):

- a. Serious allergies (medication, food, insect bites) .....  Yes  No
- b. Seizures .....  Yes  No
- c. Headaches or migraines.....  Yes  No
- d. Asthma or difficulty breathing with exercise .....  Yes  No
- e. Serious head injury or loss of consciousness .....  Yes  No
- f. Hearing loss (tubes) .....  Yes  No
- g. Speech difficulty/therapy .....  Yes  No
- h. Diagnosis of attention deficit disorder.....  Yes  No
- i. Other (diabetes, heart disease, cancer, bladder infections, etc.) .....  Yes  No

\*\*If so, please specify: \_\_\_\_\_

Any significant problems during pregnancy or at birth (including prematurity): \_\_\_\_\_

Does the student experience emotional or behavioral challenges that impact their daily life? If so, please describe: \_\_\_\_\_

Does the student have a health disability that impacts education, requires special equipment, therapy or assistance? If yes, please describe: \_\_\_\_\_

Person to be called in case of need (other than mother, father or guardian) if parent/guardian can't be reached:

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

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Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

