Thank you for your interest in Mt. Olivet Preschool!

Families currently attending Mt. Olivet Preschool may register their children starting Wednesday, February 14, 2024. General registration for all other families begins on Monday, March 4, 2024.

Registration Discount

If you register your child before May 31, 2024 and pay their first month's tuition, your registration fee of $30 will be waived.

Fees for the 2024-2025 school year are as follows:

Children are placed in classes based on their age on August 31st of the current school year.

2-year-old program
Meets Tuesdays and Wednesdays, 9-11:30 a.m.
$30.00 non-refundable registration fee
$110.00 per month for a 2 year old child

3 & 4-year-old programs
Meets Tuesdays, Wednesdays, and Thursdays, 9-11:30 a.m.
$30.00 non-refundable registration fee
$135.00 per month tuition for three mornings per week

Families with more than one child in the preschool will receive a 10% discount on their total tuition charge.

A record of lead screening is required with a students' medical information.

For additional information contact the Preschool Administrator,
Linda Stephenson,
at 302-249-8414 or via email @ MtOlivetPreschool@gmail.com.

Messages can be left at the Mt. Olivet UMC Office at 302-629-4458.

Mt. Olivet Preschool
315 High Street
Seaford, Delaware 19973
302.629.4458

Application for: (check one)
Current Student: ____
Sibling of current student: ____
New Student: ____

Date: ____________

Program Requested: (check one)
Two-year-old ____ (Must be 2 by 8-31-24)
Three-year-old ____ (Must be 3 by 8-31-24)
Four-year-old ____ (Must by 4 by 8-31-24)

Child's Name____ Sex____

Address____

Date of Birth________________ Nickname____________ Phone____________________

Who has primary custody of this child? ____

Would you like the Preschool newsletter e-mailed to you? ___yes ___no e-mail____________________

* * * * * * * * * *

Mother's Name____

Address______________________________________ Home Phone ______________
Cell Phone ______________
Employer_____________________________________ Work Phone ______________

* * * * * * * * * *

Father's Name____

Address______________________________________ Home Phone ______________
Cell Phone ______________
Employer_____________________________________ Work Phone ______________

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Names and Ages of Siblings____

____

What is your child's primary language?_______________ Second language?_______________

Does your child need any special considerations? Yes___ No ___ If yes, please explain the need.____________

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List two people who could be contacted in an emergency, if a parent could not be reached.

____
Name Relationship Phone

____
Name Relationship Phone

The immunizations required for this program are: **DPT 1, 2, 3; the Polio Vaccine 1, 2, 3; HIB 1, 2, 3; HEP B 1, 2, 3; MMR and Varicella.**

The State of Delaware requires each child have a Health Appraisal by a licensed physician or nurse practitioner. conducted within 6 months of when they start school. We will need a copy of this Health Appraisal on or before the first day of school.

Child's physician or source of health care ______________________________

Address ______________________________ Phone ______________

Please describe and allergies or special medical needs. ______________________________

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* * * * * * * * * *

For **EMERGENCIES** requiring immediate medical attention, your child ______________________
(child's name)
will be taken to the nearest hospital emergency room. Your signature below authorizes the responsible person at the school to have your child transported to the hospital.

Please sign to indicate your understanding of the school's policy concerning medical emergency situations.

Parent Signature ______________________________ Date ______________

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Field Trip Permission: I give my child, ______________________________,
(child's name)
permission to go on all field trips during school hours for the 2024-2025 school year. I understand that the school does not arrange transportation. Prior notice of all trips will be given.

Please sign to indicate your understanding of the school's policy concerning field trips.

Parent Signature ______________________________ Date ______________

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Non-Parent Caregiver Information

Caregiver's Name ______________________________ Relationship ______________

Address ______________________________

Home Phone ______________ Cell Phone ______________

Note: A non-refundable registration fee **must** be submitted with this application.
Checks should be made payable to Mt. Olivet Preschool.