St. John the Baptist Catholic School
315 N. Constitution Avenue
New Freedom, PA 17349
717-235-3525

St. John's Preschool Registration 2025-2026

Please see the attached information for 2025-2026 preschool registration. Please complete the registration, tuition agreement and emergency contact forms and return them with the registration fee. The attached health assessment form along with your child's immunization records need to submitted before the first day of school.

A gym uniform is required for students attending PK3 and PK4. Gym class is once a week and the gym uniform may be worn to school for the entire day. The preschool gym uniforms are available to purchase on Flynn O'Hara website. Our school code is PA409
http://www.stjnschool.org/wp-content/uploads/2022/06/Uniform-Info.pdf

St. John's PTO has several Spirit Wear Sales throughout the school year and the preschool gym uniform is available for purchase during those sales. Information will be emailed regarding the dates of the PTO Spirit Wear Sales.

Preschool registration for the 2025-2026 school year begins for current students on Friday, January 17, 2025.

Preschool registration will open to the public at our Open House on Sunday, January 26, 2025.

We are pleased to offer the following classes:

PK3 Classes are intended for children who will be 3 years old by August 31st:

- Two days a week on Tuesday and Thursday from 9:00 AM -11:30 AM
- Three days a week on Monday, Wednesday and Friday from 9:00 AM -11:30 AM

PK4 Classes are intended for children who will be 4 years old by August 31st:

- Three days a week on Monday, Wednesday, and Friday from 9:00 AM - 1:00 PM
- Five days a week, Monday through Friday from 9:00 AM - 1:00 PM
- Five days a week, Monday through Friday from 9:00 AM - 3:15 PM

If you have any questions, please feel free to contact the school secretary, Patty Mazziott at 717-235-2535 x230 or pmazziott@sjbnf.org

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Preschool Tuition Agreement 2025-2026

Student Name_____ Date of Birth _____

St. John the Baptist Preschool is passionate about the development of the whole child; providing for their spiritual, educational, emotional and physical needs. Our curriculum and staff will prepare your child for their future years in elementary school and beyond by providing a nurturing and engaging classroom environment.

PK3 – This level is intended for children who will be 3 years old by Aug. 31st
This prekindergarten program offers 2 schedules: 2 days a week on Tuesday & Thursday and 3 days a week on Monday, Wednesday and Friday. These classes introduce the children to a classroom setting, develop social skills and build confidence while working on the academic development intended for this age level.

PK4 - This level is intended for children who will be 4 years old by Aug. 31st
This prekindergarten program offers 2 schedules: 5 days a week, Monday – Friday and 3 days a week on Monday, Wednesday and Friday. Kindergarten readiness is the goal of these classes. The focus is to help the students develop their fine motor skills, recognition of letters, numbers, beginning sounds, shapes and colors while continuing to work on social skills, ability to follow directions and build confidence. Please send a lunch to school with your child for the PK4 classes.

Little Angels – This extended care program is available for children enrolled at St. John's for an additional fee. Information about this program is available upon request.

My child will need Little Angels care: ____ No ____Yes If yes, please note days and times _____

Please Select Class	Class	Class Days	Class Hours	Yearly Tuition
	PK3 T/Th	Tues. & Thurs.	9:00 – 11:30	$1,300
	PK3 MWF	Mon., Wed., Fri.	9:00 – 11:30	$1,775
	PK4 MWF	Mon., Wed., Fri. - bring lunch	9:00 – 1:00	$2,315
	PK4 M-F	Monday – Friday – bring lunch	9:00 – 1:00	$3,245
	PK4 FD	Monday – Friday – bring lunch	9:00 – 3:15	$4,635

I/We, the undersigned, understand that a non-refundable registration fee of $100 is due at the time of registration.
I/We, the undersigned, understand that an account must be established with Simple Tuition Solutions and will be required to select a payment plan.
I/We, the undersigned, understand that families are obligated to fulfill the entire year of tuition regardless of a withdrawal date.
I/We, the undersigned have listed persons to whom my/our child can be released on the Emergency Contact form.

Parent Name_____ Parent Signature _____ Date_____

Parent Name_____ Parent Signature _____ Date_____

Director's Signature _____ Admission Date _____ Withdrawal Date _____

OFFICE USE ONLY:
Registration Date_____ Registration Fee: Cash_____ Check# _____

Original/Student File Copy/Parent

REVISED
1/15/2025

ST. JOHN THE BAPTIST CATHOLIC SCHOOL
315 N. CONSTITUTION AVENUE
NEW FREEDOM, PA 17349
717-235-3525

2025-2026 Preschool Registration

Family Information

Please select one: ___ New Family ___ Current Family ___ Returning Family

Child's Name _____
(Last) (First) (Middle)

Nickname/Name Child Goes By _____ Birth Date _____ Gender _____

Student Address _____ City _____ State_____ Zip _____

Religion _____ Ethnicity_____ Race_____

Parents or Guardian with whom the child lives: _____ #of people at home _____

Siblings: Names, Ages_____

Please list any other persons living with the child and their relationship to the child:

_____

Are you presently a registered member of St. John the Baptist Parish? Yes_____ No_____

Mother's Full Name _____ Religion _____

Mother's Address _____ City _____ State _____ Zip _____

Mother's Email_____ Cell # _____

Father's Full Name _____ Religion _____

Father's Address _____ City _____ State _____ Zip _____

Father's Email_____ Cell # _____

Personal History

Please indicate previous preschool experience: _____Play Group _____Preschool _____Day Care ____None

_____Babysitter with other children _____Other, please indicate _____

Please provide any information that would be helpful to ease your child's transition to preschool, such as child's communication, toileting, discipline, comforting, etc.

_____

_____

Daycare Provider on Class Days (if applicable): Name _____ Phone _____

Emergency Contacts

Student Name:_____

Emergency contact person(s) other than parents. Please indicate if your child may be released to this person in an emergency if you cannot be contacted.

1st Contact's Name _____ Cell Phone _____

Address _____ City/State/Zip _____

May your child be released to this person? ___Yes ___No Relationship to Student _____

2nd Contact's Name _____ Cell Phone _____

Address _____ City/State/Zip _____

May your child be released to this person? ___Yes ___No Relationship to Student _____

Please list any persons who are authorized to pick-up your child:_____

Please list any persons who may **NOT** pick-up your child:_____

Please list the school district in which you reside _____

Please indicate if your contact information may be shared with the families in your child's class. _____Yes _____No

I/We, the undersigned, will provide a Health Assessment signed and dated by my child's physician and a copy of my child's immunization records on or before the first day of school.

I/We the undersigned, agree to update the information provided on Emergency Care Form whenever changes occur or every 6 months at a minimum. (55 PA Code §3270.124, 3280.124, 3290.12)

I/We, the undersigned, ☐ Do / ☐ Do NOT consent for (child's name)_____ to be photographed, videotaped or digitally recorded to appear on St. John the Baptist School's website, newsletters, social media pages, over the Diocese of Harrisburg's Wide Area Network.(WAN), through the use of web camera, and/or through video conferencing and advertisement during the school year. I/We understand that the child's picture(s) will be on display for the reason of promotional purposes. I/We further acknowledge the child's name may be used in connection with his/her picture, videotape or digital recording. I/We hereby agree on behalf of the above named child and with the agreement of his/her other parent or legal guardian to waive any claims against St. John's Catholic School, the Diocese of Harrisburg, and any diocesan agents or employees, which may arise from the use of said picture/videotape/digital recording of St. John student/students in the above described manner.

If at any time, I/we want the child photograph and/or recording to be removed from any use, I/we acknowledge that it is my/our responsibility to inform the school of this decision in writing.

Parent Name_____ Parent Signature _____ Date_____

Parent Name_____ Parent Signature _____ Date_____

Director's Signature _____ Date_____ Admission Date _____

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.