Discovery Place Preschool

32 West Chestnut Street, Hanover, PA 17331
discoveryplacehanover@gmail.com
(717) 637-1864

Registration Form 2026-2027 Preschool Year

Steps to completing registration:

Step 1: Return this completed registration form **and** non-refundable registration fee of $50.00 to Discovery Place Preschool. Checks or money orders only, **NO cash please**! This will hold your child's place in the class you select below. Other forms can wait- return THIS FORM and fee to hold your child's class placement! **We are not able to hold spots without the registration fee.**

Step 2: Return the remainder of the paperwork by August 1 to finalize your child's placement in class. Any held spots without forms and first tuition payment by August 1 will be released to waitlist families.

PLEASE NOTE: We DO require all students to be up to date on immunizations, with a signed health form from a physician's office. We do NOT require children to be fully potty-trained, but they must be working on it. They must be familiar with the potty and should wear a pull-up if needed instead of a diaper as we do not have a changing table.

Child's Name:_____ Birthdate (MM/DD/YY):_____

****PLEASE PROVIDE THE NAME THAT YOU WOULD LIKE US TO USE FOR NAME TAGS/NAME RECOGNITION/PRINTING NAME, ETC.****

Child's Gender (circle one): M F Is child potty-trained? (circle one): YES NO

Street Address:_____

Mother's Name:_____Daytime Phone:_____

Email:_____

Father's Name:_____Daytime Phone:_____

Email:_____

Child lives with (circle one): both parents primarily Mother primarily Father

School District:_____

Check the box below to indicate your class selection:

Children age 3 before Sept. 1, 2026

☐ Tues & Thurs
9:15-11:45am,
$100/mo. ($900/yr)

☐ Mon, Wed & Fri
9:15-11:45am,
$150/mo. ($1350/yr)

Children age 4 before Sept. 1, 2026

☐ Tues & Thurs
8:45-11:30am,
$110/mo. ($990/yr)

FULL

☐ Tues, Wed, & Thurs
9:00am-2:00pm
$300/mo. ($2700/yr)
(lunch brought from home)

Child's Name:_____

Please help us get to know your child by answering the following questions:

Does your child have any known allergies?_____

_____

What are some of your child's favorite things that make him/her happy (i.e. toys/stuffed animals, activities, games, movies/television shows, pets, other)?_____

_____

Does your child have any specific fears (i.e. loud noises, the dark, separation, animals, strangers, other)?_____

_____

Has your child had any previous experience in group/structured programs (i.e. daycare, sports, Sunday school)? YES / NO If yes, how was the experience:_____

_____

What do you hope our preschool will provide for your child? _____

_____

_____

Please list any additional information about your child to help us make preschool a positive experience._____

_____

_____

NEXT: Look for confirmation emails following receipt of forms. Be sure to check your "junk" email and add discoveryplacehanover@gmail.com to your contacts list! ALL PAPERWORK AND FIRST TUITION PAYMENT must be returned by August 1, 2026 to finalize your child's placement.

OFFICE USE: N R S DATE RECEIVED:_____

RF:_____ CONFIRMATION EMAIL SENT:_____

EMERGENCY CONTACT & PARENTAL CONSENT FORM

Child's Name:_____

Mother's Name:_____Home/Cell phone:_____

Work phone:_____Employer:_____

Father's Name:_____Home/Cell phone:_____

Work phone:_____Employer:_____

List in order who we should call in an emergency:

1._____#_____

2._____#_____

3._____#_____

4._____#_____

Additional person(s) to whom your child may be released other than the *PARENTS* listed above:

1._____#_____

2._____#_____

3._____#_____

4._____#_____

Child's physician/medical care provider:

_____#_____

Special needs, disabilities or allergies (include medication reactions):_____

_____

Medical or dietary information necessary in an emergency situation:_____

_____

Health insurance coverage for child or medical assistance benefits:

_____Policy #_____

Sign below to indicate your consent for administration of minor first aid (i.e. cold packs, bandaids), obtaining emergency medical care, and permission to take short walks in close proximity to our facility:

Parent signature:_____ Date:_____

Payment 9
Due BEFORE April 1, 2027

_____
Student Name

_____
Class

Tuition Amount $_____
Teacher Appreciation $_____
Donation to Preschool $_____

TOTAL $_____

Payment 8
Due BEFORE March 1, 2027

_____
Student Name

_____
Class

Tuition Amount $_____
Teacher Appreciation $_____
Donation to Preschool $_____

TOTAL $_____

Payment 7
Due BEFORE February 1, 2027

_____
Student Name

_____
Class

Tuition Amount $_____
Teacher Appreciation $_____
Donation to Preschool $_____

TOTAL $_____

Payment 6
Due BEFORE January 1, 2027

_____
Student Name

_____
Class

Tuition Amount $_____
Teacher Appreciation $_____
Donation to Preschool $_____

TOTAL $_____

Payment 5
Due BEFORE December 1, 2026

_____
Student Name

_____
Class

Tuition Amount $_____
Teacher Appreciation $_____
Donation to Preschool $_____

TOTAL $_____

Payment 4
Due BEFORE November 1, 2026

_____
Student Name

_____
Class

Tuition Amount $_____
Teacher Appreciation $_____
Donation to Preschool $_____

TOTAL $_____

Payment 3
Due BEFORE October 1, 2026

_____
Student Name

_____
Class

Tuition Amount $_____
Teacher Appreciation $_____
Donation to Preschool $_____

TOTAL $_____

Payment 2
Due BEFORE September 1, 2026

_____
Student Name

_____
Class

Tuition Amount $_____
Teacher Appreciation $_____
Donation to Preschool $_____

TOTAL $_____

Payment 1
Due BEFORE August 1, 2026

_____
Student Name

_____
Class

Tuition Amount $_____
Teacher Appreciation $_____
Donation to Preschool $_____

TOTAL $_____

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: Discovery Place Preschool		
FACILITY PHONE: 717-637-1864	COUNTY: York	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.