



**IMAGE CHRISTIAN PRESCHOOL**  
**2026-2027 School Year**  
**4017 Weddington Rd, Matthews, NC 28105**  
**704-844-6620**  
**Website: [www.imagechristianpreschool.com](http://www.imagechristianpreschool.com)**  
**Email: [imagechristianpreschool@gmail.com](mailto:imagechristianpreschool@gmail.com)**

**Registration Fee: \$150**

These fees are due at enrollment and are **non-refundable**. Registration is ongoing and continues until classes are full. The fee is refundable only in the case of the class being cancelled due to lack of enrollment.

**Tuition:** Tuition payments can be made by Zelle (preferred method) check, or cash. Zelle payments can be sent to [preschool@imagechurch.us](mailto:preschool@imagechurch.us). It will show Charles Greene as associated with the account. He is the church administrator. Tuition is due on the **1<sup>st</sup>** of the month with a **\$15** late fee added after the **10<sup>th</sup>** of the month, and a **\$20** fee added for a returned check. A 10% discount is given on tuition to each additional child enrolled. If it becomes necessary for you to withdraw your child, written notice must be received at least 2 weeks in advance. The full tuition for the month in which your child is withdrawn will be due.

**Tuition rates:**

The tuition amount is based on a yearly amount divided into 10 equal monthly payments (August – May). The amount is the same each month regardless of the number of days attended, holidays, weather closings, workdays, etc.

3 day classes are Mon/Wed/Fri and 2 day classes are Tue/Thur.

<b>1 Year Old Class</b>	<b>2 Year Old Class</b>	<b>3 Year Old Class</b>	<b>4TK Class</b>
2 days - \$250/month	2 days - \$250/month	3 days - \$300/month	5 days - \$400/month
3 days - \$325/month	3 days - \$325/month	5 days - \$400/month	
5 days - \$415/month	5 days - \$415/month		

**Class Placement:** Children will be placed in classes based upon their age as of **AUGUST 31<sup>ST</sup>** of the current school year. Children entering the three and four year old class must be toilet trained. The school reserves the right to determine whether or not to enroll a child who needs specially trained professionals to meet their developmental needs.

**School Hours: 9:00 – 12:55**

**OUR PHILOSOPHY**

The preschool program at Image Christian Preschool seeks to provide a positive, caring, Christian environment in which children may learn and grow. We believe that children develop at their own rate. We encourage exploration and learning through play while also providing structure, academic instruction, and security. Concrete hands-on experiences are provided to create an environment which helps the child grow mentally, emotionally, physically, socially, and spiritually. Every child is a unique child of God and we strive to make each child feel special and important.



# Image Christian Preschool Registration Form

The class child will enter school year 2026/2027:

<b>1 year old</b> (MWF ___ T/Th ___ 5 days ___)	<b>2 year old</b> (MWF ___ T/Th ___ 5 days ___)
<b>3 year old</b> (MWF ___ 5 days ___)	<b>4TK</b> (5 days ___)
<b>(Cutoff date for classes: Age as of August 31<sup>st</sup> determines class placement for the year.)</b>	

Child's full name \_\_\_\_\_  
(first) (middle) (last)

Name to be called \_\_\_\_\_ Birthdate \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Home address: Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

### FAMILY INFORMATION

Father's name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Where employed \_\_\_\_\_ Work # \_\_\_\_\_

Email address \_\_\_\_\_

Mother's Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Where employed \_\_\_\_\_ Work # \_\_\_\_\_

Email address \_\_\_\_\_

Siblings (Name and Age)

\_\_\_\_\_

### PERSONAL HISTORY

Previous preschool experience? \_\_\_\_\_

Does child have any allergies or other medical issues? \_\_\_\_\_

\_\_\_\_\_

Share any information concerning your child which will be helpful in their preschool experience:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How did you hear about our program? \_\_\_\_\_



## **Image Christian Preschool Permission for Emergency Care**

**CHILD'S FULL NAME** \_\_\_\_\_

**BIRTHDATE** \_\_\_\_\_

In the event of an accident or injury, I authorize the staff of Image Christian Preschool to provide any first aid deemed necessary for my child.

In the event of an emergency, I authorize the staff of Image Christian Preschool to secure emergency medical attention for my child. The paramedics and/or attending physician at the hospital's emergency room are hereby authorized to provide any emergency care deemed necessary for my child.

I hereby release and hold harmless Image Christian Preschool, Image Church, and any of its staff from any liability as a result of personal injury or sickness that may occur while my child is in the care of Image Christian Preschool.

I understand that this authorization is valid the entire time that my child is a student at Image Christian Preschool. It is only voided when I give written notification of withdrawal of my child from Image Christian Preschool.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)



# Image Christian Preschool Photography/Video Consent

Throughout the year, the staff of Image Christian Preschool may use photographs of your child for craft projects, to make a DVD to show at the End of the Year Program, and/or make photo albums to give to your child that highlights events from the entire year. We may also video special programs or activities. We may use such photographs and/or videos to display on our website, Facebook page, newsletters, brochures, and other school publications. Such photographs and/or videos will only be used by Image Christian Preschool for the purpose of entertainment, communication, and/or promotion for the school. We will only photograph and/or video your child with your permission and you may choose in what capacity you would like your child's information shared. Please direct any questions and/or concerns to the Director.

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Child's Full Name \_\_\_\_\_  
Birthdate \_\_\_\_\_

Please **INITIAL** beside the statement that you agree to and sign below:

\_\_\_\_\_ I give Image Christian Preschool permission to photograph and/or video my child during preschool events. I understand that these items may be used within the school for projects and/or may be displayed on the website, brochures, Facebook page, and other school publications.

\_\_\_\_\_ I give Image Christian Preschool permission to photograph and/or video my child during preschool events. I give permission for these items to only be used within the school for projects. I **DO NOT** authorize them to be displayed on the website, brochures, Facebook page, and other school publications.

I understand that this authorization is valid until I request otherwise in writing.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## MEDICAL INFORMATION

(This form should be filled out by a physician and returned to the center within 30 days of enrollment)

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_

Clinic Name \_\_\_\_\_ Clinic Phone \_\_\_\_\_

Doctor's Name \_\_\_\_\_

### PAST HISTORY

(May be completed by Parent)

Is child allergic to anything? No \_\_\_\_ Yes \_\_\_\_ If yes, what? \_\_\_\_\_

Is child currently under a doctor's care? No \_\_\_\_ Yes \_\_\_\_ If yes, for what reason? \_\_\_\_\_

Is the child on any continuous medication? No \_\_\_\_ Yes \_\_\_\_ If yes, what? \_\_\_\_\_

Any previous hospitalizations or operations? No \_\_\_\_ Yes \_\_\_\_ If yes, when and for what? \_\_\_\_\_

Any history of significant previous diseases or recurrent illness? No \_\_\_\_ Yes \_\_\_\_

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

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

### PHYSICAL EXAMINATION

(This examination must be completed and signed by a licensed physician)

State the status of the following and note any specific health problems:

Height \_\_\_\_\_ Weight \_\_\_\_\_ Head \_\_\_\_\_ Eyes \_\_\_\_\_ Ears \_\_\_\_\_

Nose \_\_\_\_\_ Teeth \_\_\_\_\_ Throat \_\_\_\_\_ Neck \_\_\_\_\_ Heart \_\_\_\_\_ Chest \_\_\_\_\_

Skin \_\_\_\_\_ Vision \_\_\_\_\_ Hearing \_\_\_\_\_

Any specific problems or other recommendations? \_\_\_\_\_

Date of Examination \_\_\_\_\_ Signature of Physician \_\_\_\_\_

**Attach a copy of immunization record.**