



FOR OFFICE USE ONLY

CLASS ASSIGNED _____

PACKET RECEIVED: _____

DATE ENROLLED _____

St. Paul's Evangelical Lutheran Church
HILLTOP CHRISTIAN EARLY LEARNING CENTER
837 Charles Street, Torrington, CT 06790
Phone: (860)482-3727

2025-2026 St. Paul's Hilltop Christian Early Learning Center Registration

ABOUT THE CHILD

Last Name _____ First Name _____ Middle Initial _____

Name you would like your child to know/recognize _____

Child's Address _____ Primary Phone _____

Mailing Address _____

City/State/Zip _____ Date of Birth ____/____/____ Male Female

Optional: Race/Ethnic Category: ☐ American Indian ☐ Asian ☐ Black, not of Hispanic Origin

☐ White, not of Hispanic Origin ☐ Hispanic/Latino Other _____

About Parents

Parent 1 Full name _____ e-mail address _____

Parent 1 Address: Same as child's or: _____

Occupation _____ Employer _____ Employer's address _____

Phone Numbers: Work (____) _____ ext ____ Cell (____) _____ Other (____) _____

Parent 2 Full name _____ e-mail address _____

Parent 2 address: Same as child's or: _____

Occupation _____ Employer _____ Employer's address _____

Phone Numbers: Work (____) _____ ext ____ Cell (____) _____ Other (____) _____

Child's Living Arrangement: _____ How many family members are in the same home? _____

LIVES WITH: Both Parents Mother Father Guardian * Other * *Relationship to Child _____

*Full Name (if other than parent) _____

*Address _____ City/State/Zip _____

*Phone Numbers: Work (____) _____ ext ____ Cell (____) _____ Other (____) _____

Family Languages:

What language did your child learn to speak first? _____

What is the primary language spoken by parents or guardians in the home? _____

What is the primary language spoken by your child at home? _____

Who speaks English in your home? _____

Additional Questions:

How did you hear about Hilltop? _____

Are you an active member of St. Paul's? Yes No

Do you have a child currently enrolled in Hilltop? Yes No

Local people to contact when parents are unavailable:

Full name of 1st contact: _____ Telephone _____)

Address _____ Relationship _____

Full name of 2nd contact: _____ Telephone _____

Address _____ Relationship _____

Full name of 3rd contact: _____ Telephone # (_____) _____

Address _____ Relationship _____

Names of Child's Brothers	Age	Date of Birth		Names of Child's Sisters	Age	Date of Birth

Child's Health History

Physician's Name _____ Town _____ Phone # (_____) _____

Is your child regularly or intermittently on any medications? Yes No

If yes, please name the medication(s) _____

How often is it given? _____

Doctor that ordered the medication: _____ Town _____ Phone # (_____) _____

Does your child have asthma? Yes ☐ No ☐Does your child use an inhaler or nebulizer (electronic machine with inhaler medication)? Yes ☐ No ☐

If yes, how often? Seasonally only Regularly throughout the year Only when ill

List your child's allergies (food, medications, seasonal, other) _____

Children must have flu vaccine by the end of December in the year they are first enrolled and each subsequent year thereafter.

Is your child prescribed an Epi Pen? Yes ☐ No ☐

List any restrictions your child has (Physical, non-allergy diet, other) _____

PLEASE NOTE: Your child **MUST** be potty trained at the beginning of the school year. (This does not apply to children in the 2-year-old class)**Additional comments from parents/guardians:**

Parent\Guardian Signature _____ Date _____

PLEASE INCLUDE A \$90.00 registration fee. 2 OR MORE CHILDREN: \$120.00 per family

This fee is NON-REFUNDABLE**PLEASE MAKE CHECKS PAYABLE TO: ST. PAUL'S** Check# _____ Cash _____ Date _____ Time _____

Hilltop is an equal opportunity employer and educational institution and does not discriminate on the basis of race, religion, color, sex, national origin, age, or handicap, nor does it tolerate sexual harassment.

Child's Name _____

*Classes may be
combined or
cancelled
pending low
enrollment at
the discretion
of the
Hilltop
Advisory
Committee*

CLASSROOM CHOICES: (Please check the choice that best suits you and your child)

<u>Age</u>	<u>Days of the week</u>	<u>Time</u>
CHILD MUST TURN 2 YEARS OF AGE BY SEPTEMBER 1ST		
<input type="checkbox"/> 2-year-olds	***Tuesday/Thursday <u>ONLY</u>	9:30a – 11:30a
****CHILD MUST TURN 3 YEARS OF AGE BY SEPTEMBER 1ST****		
<input type="checkbox"/> 3-year-olds	****MWF Part day session	9:30a – 12:00 noon
<input type="checkbox"/> 3-year-olds	****MWF Full day session	9:30a – 2:30p
<input type="checkbox"/> 4-year-olds	5 Full day session	9:15a – 2:45p
<input type="checkbox"/> 4-year-olds	4 Full day session	9:15a – 2:45p
<input type="checkbox"/> 4-year-olds	3 Full day session	9:15a – 2:45p

PLEASE NOTE: Priority is given to students choosing 4 or 5 Full day sessions. Please speak with Mrs. Mazzei with any questions.

- ☐ *Early Start CT (ESCT) M-F Full day session 9:00a – 3:00p
(Formerly School Readiness)

***Families must meet income and residency requirements for this classroom**