



**CIRCLE OF LOVE
APPLICATION FORM
(Sibling)**
Website: circleoflovemb.org
Please Print Clearly

For Office Use Only:

Registration: _____
 Deposit: _____
 Paid: _____
 Check #: _____
QB R Dir _____

CHILD'S INFORMATION

Name of Child: _____ Gender: M F
 (PLEASE CIRCLE)

Age (as of September) _____ Date of Birth: _____

Address: _____

City: _____ Zip code: _____

PARENT INFORMATION

Mother's Name:	Father's name:
Phone (Home) :	Phone (Home)
(Cell) :	(Cell) :
(Work) :	(Work) :
Email:	Email:

SCHEDULE PREFERENCES

- PRESCHOOL** (Please circle your desired days and times)
- 1st choice: M TU W TH F 9-12:30 FULL DAYS
- 2nd choice: M TU W TH F 9-12:30 FULL DAYS
- 3rd choice: M TU W TH F 9-12:30 FULL DAYS

- TRANSITIONAL KINDERGARTEN**
Offered Monday thru Friday at 9:00 a.m. – 12:30 p.m. for children who turn 5 years of age in August, September, October, and November. Exceptions may be considered at the discretion of the director.

Parent Signature _____

Date _____