



**Gregorian Learning and Development Center**  
4680 Nottingham Way  
Hamilton Square, New Jersey 08690  
(609) 587-1131 Ext. 3



**Read To Me**  
**Program for "ALMOST" Three-Year-Olds**  
**Friday 8:45 - 10:15 am**  
**Place: Parish Center**

A child's first all-by-myself experience. Each 90 minute session introduces a new story accompanied by crafts and games to enhance your child's learning experience. Snack included!


*Teachers: Mrs. Quaste, Mrs. Cincotta and Mrs. Andria*  
Read to Me for Young Threes

**Fall Session**  
**Winter Session**  
**Spring Session**

Each session is 5 weeks  
Please e-mail [GLDC@stgregorythegreatchurch.org](mailto:GLDC@stgregorythegreatchurch.org) for session dates.

**Schedule**

8:45 Arrive

- . Story Time
- . Craft Time
- . Snack time
-  Play time

10:15 Dismissal

90 minutes of reading and social fun!  
Each Session Cost: \$90.00



**READ TO ME  
REGISTRATION FORM**



Child's Name: \_\_\_\_\_  
 Birthday: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Father's First Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Place of Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Father's Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Mother's First Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Place of Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Mother's Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

**FAMILY INFORMATION**

\_\_\_\_\_ will pick up my child. Parents should be in the Parish Center foyer by 10:10 am.

Information you may wish to share with the teacher, i.e.: special eating or sleeping habits, speech or hearing, pets, etc:

Specify any allergies, such as medications, bee stings or food:  
 \_\_\_\_\_  
 \_\_\_\_\_

**EMERGENCY INFORMATION**

List the names and phone number of one person we may call in case of emergency if the parents cannot be reached (relative, neighbor, friend, etc.):

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**EMERGENCY PERMISSION SLIP**

There is always a possibility that a child may be injured or become seriously ill during school hours and that we may be unable to reach the parents. Medical aid cannot be given to a child without his/her parent's consent. In an emergency, time can be vital.

We would like to have your signature on file in case such an emergency arises and we are unable to reach you immediately. We pray that it will never be necessary to use it. Please fill in the form below and return it to the pre-school.

I give permission for my child, \_\_\_\_\_, to be transported to the Emergency Room at the hospital for medical aid in case of extreme emergency, provided I cannot be contacted at the time.

I prefer my child be taken to:      (    ) Robert Wood Johnson Medical Center at Hamilton  
(    ) St. Francis Hospital      (    ) Capital Health System

Child's doctor: \_\_\_\_\_

**Parent's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Payment for each session is due two weeks in advance.**

*If space is not available, we will have a "hoping list" for our Sessions. You will be contacted if there is an opening.*

*Payment will be returned if space is not available.*

**A confirmation will be e-mailed one week prior to the start of the program.**