Bethany
LUTHERAN PRESCHOOL

Bethany Lutheran Preschool
2501 Beacon Hill Road
Alexandria, VA 22306

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Bethany Lutheran Church

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OFFICE@bethany-lcms.org

**Serving God's Children and their families since 1959**

January 27, 2020

## Early Registration

Dear BLPS Family,

Now is the time to think about registration for the 2020-2021 School Year! Enclosed in this envelope are registration forms for students or siblings who will be attending BLPS this Fall. If you are uncertain about class placement for your child, please speak with your child's current teacher or stop by the Preschool Office.

Registration for current families (including Mom's Day Out families) begins Monday, January 27th. We will open registration to the community on Monday, February 10th.

There is a non-refundable registration fee of $135 due with your registration forms. However, if you register prior to Wednesday, February 22nd, your registration fee will be discounted to $125. All additional siblings will receive a $10 discount on their registration fee.

At the time of registration, parents must submit the following items:

- Registration Form
- Parent Questionnaire
- Emergency Information Form

By August 15th, parents must submit the following items:

- Health Form
- Child's Proof of Identity (i.e. Birth Certificate or Passport)

If you have any questions, please feel free to call, email, or stop by the Preschool Office. If BLPS is not in your plans for next school year, we would love for you to share this information with your friends and neighbors. May God continue to guide you in your decisions concerning your child's education.

In His Service,

Olivia Taylor, M.S. Ed.
Preschool Director

**BETHANY LUTHERAN CHURCH AND PRESCHOOL**
2501 Beacon Hill Road Alexandria, Virginia 22306
703-765-TOTS (8687) Preschool@Bethany-LCMS.org

# 2020 - 2021 Registration

*Serving God's Children and Their Families Since 1959*

Child's Name _____ Date _____

Name your child is called _____ Gender _____

Birth date _____/_____/_____ Age of child on 9/30/20 _____ yrs. _____ months
mm / dd / yy

## REGISTRATION INFORMATION

**Bethany Lutheran Preschool admits students of any race, color, religion, or national or ethnic origin.**

**Registration and Materials fee: $135** with a $10 discount for each additional family member.
The registration fee is not refundable unless minimum enrollment requirements are not met.
The school reserves the right to make class assignments. Make checks payable to Bethany Lutheran Preschool.

## CLASS OFFERINGS

Tuition is an annual fee. Payment choices include tuition paid-in-full, semi-annual (twice per school year), or a 10-month plan.
Class hours are 9:00 a.m. – 1:00 p.m.

**☒ Please mark an 'X' in the box to indicate your class choice.**

| **PRE-KINDERGARTEN**<br>**4 by Sept 30** | ☐ **Five Day Class**<br>Monday - Friday |
|---|---|
| **Annual Tuition** | $5,300 |
| **Semi-annual Tuition** | $2,650 |
| **10 Monthly Payments** | $530 |
| **Special Material Fee** | $25 (one-time fee) |

| **THREE-YEAR-OLDS**<br>**3 by Sept 30** | ☐ **Five Day Class**<br>Monday - Friday | ☐ **Three Day Class**<br>Monday/Wednesday/Friday |
|---|---|---|
| **Annual Tuition** | $5,300 | $3,300 |
| **Semi-annual Tuition** | $2,650 | $1,650 |
| **10 Monthly Payments** | $530 | $330 |

Children do not need to be potty-trained for Twos and Toddlers classes.

| **TWO-YEAR-OLDS**<br>**2 by Sept 30**<br>**and TODDLERS**<br>**20 months by Sept 30** | ☐ **Five Day Class**<br>Monday - Friday | ☐ **Three Day Class**<br>Monday/Wednesday/Friday | ☐ **Two Day Class**<br>Tuesday/Thursday |
|---|---|---|---|
| **Annual Tuition** | $5,800 | $3,800 | $2,800 |
| **Semi-annual Tuition** | $2,900 | $1,900 | $1,400 |
| **10 Monthly Payments** | $580 | $380 | $280 |

**Terms for payment of tuition:**
1. A registration fee is due at time of registration. *This fee is non-refundable.*
2. The first tuition payment is due September 1st. Payment choices include paying in full, twice per school year, or each month for ten months. Monthly payments begin September 1st and continue through June 1st.
3. If a child is registered after September 3rd, tuition will be prorated. The first payment is due with registration. Subsequent payments are due the 1st of each month.
4. Parents must give forty-five (45) days notice of withdrawal to the Preschool office. If less than 45 days notice is given, parents are responsible for tuition for the 45 days from the date of written notification.
5. ***September tuition installments are not refundable after August 1st.***

(Please initial here) _____

Office Use Only

Date reg. pd. _____ Ck. # _____ Amn't. _____

1st tuition payment date _____ Ck # _____ Amn't. _____ PreK Materials Fee _____

Placement - class and date _____ Acknowledgment letter _____

## FORMS and PERMISSIONS

### REQUIRED DOCUMENTATION - Due by August 15, 2020

The Commonwealth of Virginia requires each student to have on file:

- Proof of Identity (via birth certificate, hospital letter of birth, or passport) – a copy is put into the file.
- Health Form to include a complete physical and up-to-date immunizations (Ref. Code of Virginia § 22.1-270). *Students may not participate in classes without this form on file.*

(Please initial here) _____

**Family and Emergency Information Form** – *Please return to the preschool office at the time of registration.*

In the event your child becomes ill or injured, staff will attempt to first notify parents or call emergency contacts. If the event is deemed an emergency, the school will call 911. The FAMILY AND EMERGENCY INFORMATION form is shared with emergency responders.

In the event your child becomes ill, staff will attempt to first notify parents and the parent agrees to pick up their child in a timely manner. If parents cannot be reached, staff will call emergency contacts to pick up the child.

***In case of an emergency, the school will contact 911.***
***Every attempt will be made to contact a parent or designated emergency contact.***

(Please initial here) _____

**Photograph Permission**

During the school year, photos are taken of class activities, special events, for classroom displays, etc. Please initial on the line to give Bethany Lutheran Preschool permission to display in the classroom or hall, publish in print, on our website or on the Preschool Facebook page, photos that include your child.

(Please initial here) _____

**Class Lists**

Each student receives a list of classmates with contact information. This resource is great for coordinating play dates, helping with transportation needs, sending party invitations, etc. The class list will include the student's name, address, parents' names, address, phone number, and email address. Please initial on the line to give Bethany Lutheran Preschool permission to include your child's information on the class list.

(Please initial here) _____

Signature of parent or legal guardian _____ Date _____

Bethany

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# FAMILY AND EMERGENCY INFORMATION

Page 1 of this form is shared with emergency responders.

| Name of Child<br><br>With whom does the child reside? | Date of Birth | Gender |
|---|---|---|

| PARENT/GUARDIAN INFORMATION | |
|---|---|
| **FIRST CONTACT** | **SECOND CONTACT** |
| **Name** | **Name** |
| **Address** | **Address** |
| **Home phone** | **Home phone** |
| **Cell phone** | **Cell phone** |
| **Place of Employment** | **Place of Employment** |
| **Work phone** | **Work phone** |
| **E-mail address** | **E-mail address** |

**Please list—in order—who to contact in case of an emergency.**
Please list 2 **local** contacts, other than parents, who have permission to pick up your child from school.

| Name | Phone Numbers | Relationship to child |
|---|---|---|
| | | |
| | | |
| | | |

**List all medications and dosages your child receives on a continual basis.**

| Name of medication | Dosage | Frequency | Behavioral affects (if any) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**List any allergies your child may have**

| Allergy | Symptoms | Treatment | Special Concern |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Current Health Conditions: Please indicate any current health conditions, including allergies, that need to brought to the attention of emergency personnel:** _____

_____

_____

_____

My child's medical care is provided by _____ (Name of doctor, clinic, HMO) _____ (Phone)

Does your child have health insurance? _____

If yes, medical coverage is provided by _____ (Name of insurance company) _____ (ID/Group Number)

Name of Participant _____ Relationship to child _____

Parent signature _____ Date _____

## STUDENT INFORMATION
**WE ARE A TREE NUT and PEANUT-FREE SCHOOL.**

Names and ages of child's siblings _____

_____

Primary language spoken at home _____

If not English, what is the national origin of your primary language? _____

What is your family's church affiliation (e.g. Lutheran, Christian, Muslim, none) _____

How did you learn about Bethany Lutheran Preschool? _____

If referred by a friend, what is their name? _____

Has your child previously attended preschool or day care? _____

List any physical concerns, pertinent developmental information, etc. that would affect participation in school activities.

_____

Does your child receive developmental services or has developmental testing or services been recommended? _____

If yes, please explain: _____

_____

### DEVELOPMENTAL MILESTONES

At what age did your child: crawl _____ walk _____ begin to feed self _____

say first words _____ use two-word phrases _____ use short sentences _____

Check the statements that describe your child. You may make any comments or clarifications.

| | |
|---|---|
| | Is generally happy |
| | Enjoys playing with children his/her age |
| | Is fully potty trained during the day |
| | Dresses himself with minimal help |
| | Can be left with a babysitter that is not a family member |
| | Is very sensitive to certain sounds (ex. vacuum, noise of large groups, music) |
| | Can sit and listen to a storybook |
| | Is comfortable with new people or places |
| | Cries easily |
| | Is very social |
| | Can be understood when speaking to strangers or other non-family members |
| | Is loved by family |

Other information you would like to share about your child: _____

_____

_____

_____

_____

Parent signature _____ Date _____

# COMMONWEALTH OF VIRGINIA
# SCHOOL ENTRANCE HEALTH FORM
## Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

### Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no longer than one year before your child's entry into school.

Name of School: _____ Current Grade: _____

Student's Name: _____
Last First Middle

Student's Date of Birth: ____/____/_____ Sex: _____ State or Country of Birth: _____ Main Language Spoken: _____

Student's Address: _____ City: _____ State: _____ Zip: _____

Name of Parent or Legal Guardian 1: _____ Phone: ____-____-_____ Work or Cell: ____-____-_____

Name of Parent or Legal Guardian 2: _____ Phone: ____-____-_____ Work or Cell: ____-____-_____

Emergency Contact: _____ Phone: ____-____-_____ Work or Cell: ____-____-_____

| Condition | Yes | Comments | Condition | Yes | Comments |
|---|---|---|---|---|---|
| Allergies (food, insects, drugs, latex) | | | Diabetes | | |
| Allergies (seasonal) | | | Head injury, concussions | | |
| Asthma or breathing problems | | | Hearing problems or deafness | | |
| Attention-Deficit/Hyperactivity Disorder | | | Heart problems | | |
| Behavioral problems | | | Lead poisoning | | |
| Developmental problems | | | Muscle problems | | |
| Bladder problem | | | Seizures | | |
| Bleeding problem | | | Sickle Cell Disease (not trait) | | |
| Bowel problem | | | Speech problems | | |
| Cerebral Palsy | | | Spinal injury | | |
| Cystic fibrosis | | | Surgery | | |
| Dental problems | | | Vision problems | | |

Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.): _____

List all prescription, over-the-counter, and herbal medications your child takes regularly: _____

Check here if you want to discuss confidential information with the school nurse or other school authority. ☐ Yes ☐ No

Please provide the following information:

| | Name | Phone | Date of Last Appointment |
|---|---|---|---|
| Pediatrician/primary care provider | | | |
| Specialist | | | |
| Dentist | | | |
| Case Worker (if applicable) | | | |

Child's Health Insurance: ____ None ____ FAMIS Plus (Medicaid) _____ FAMIS _____ Private/Commercial/Employer sponsored

**I, _____ (do___) (do not___) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form.** *This authorization will be in place until or unless you withdraw it.* ***You may withdraw your authorization at any time by contacting your child's school.*** *When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.*

**Signature** of Parent or Legal Guardian: _____ Date: _____/_____/_____

**Signature** of person completing this form: _____ Date: _____/_____/_____

**Signature** of Interpreter: _____ Date: _____/_____/_____

**COMMONWEALTH OF VIRGINIA**
**SCHOOL ENTRANCE HEALTH FORM**

**Part II - Certification of Immunization**

***Section I***

**To be completed by a physician or his designee, registered nurse, or health department official.**
**See Section II for conditional enrollment and exemptions.**

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.
Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name: _____ Date of Birth: |__|__|__|
*Last* *First* *Middle* *Mo. Day Yr.*

| IMMUNIZATION | RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN | | | | |
|---|---|---|---|---|---|
| *Diphtheria, Tetanus, Pertussis (DTP, DTaP) | 1 | 2 | 3 | 4 | 5 |
| *Diphtheria, Tetanus (DT) or Td (given after 7 years of age) | 1 | 2 | 3 | 4 | 5 |
| *Tdap booster (6th grade entry) | 1 | | | | |
| *Poliomyelitis (IPV, OPV) | 1 | 2 | 3 | 4 | |
| *Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age | 1 | 2 | 3 | 4 | |
| *Pneumococcal (PCV conjugate) *only for children <60 months of age | 1 | 2 | 3 | 4 | |
| Measles, Mumps, Rubella (MMR vaccine) | 1 | 2 | | | |
| *Measles (Rubeola) | 1 | 2 | Serological Confirmation of Measles Immunity: | | |
| *Rubella | 1 | | Serological Confirmation of Rubella Immunity: | | |
| *Mumps | 1 | 2 | | | |
| *Hepatitis B Vaccine (HBV) ☐ Merck adult formulation used | 1 | 2 | 3 | | |
| *Varicella Vaccine | 1 | 2 | Date of Varicella Disease OR Serological Confirmation of Varicella Immunity: | | |
| Hepatitis A Vaccine | 1 | 2 | | | |
| Meningococcal Vaccine | 1 | | | | |
| Human Papillomavirus Vaccine | 1 | 2 | 3 | | |
| Other | 1 | 2 | 3 | 4 | 5 |
| Other | 1 | 2 | 3 | 4 | 5 |

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Reference Section III).

**Signature of Medical Provider or Health Department Official:** _____ **Date (*Mo., Day, Yr.*):** __/__/____

Student's Name:_____ Date of Birth: |___|_ __|___|_ _|

## *Section II*
## *Conditional Enrollment and Exemptions*

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.

**MEDICAL EXEMPTION:** As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____

_____

_____.

DTP/DTaP/Tdap:[___]; DT/Td:[___]; OPV/IPV:[___]; Hib:[___]; Pneum:[___]; Measles:[___]; Rubella:[___]; Mumps:[___]; HBV:[___]; Varicella:[___]

This contraindication is permanent: [___], or temporary [___] and expected to preclude immunizations until: Date (*Mo., Day, Yr.*): |___|___|___|.

**Signature of Medical Provider or Health Department Official:**_____ **Date (*Mo., Day, Yr.*):**|___|___|___|

**RELIGIOUS EXEMPTION:** The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

**CONDITIONAL ENROLLMENT:** As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on _____.

**Signature of Medical Provider or Health Department Official:**_____ **Date (*Mo., Day, Yr.*):**|___|___|___|

## *Section III*
## *Requirements*

**For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization**

**Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations** (Ref. *Code of Virginia* § 32.1-46(a)).
**(Requirements are subject to change.)**

## Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

**A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III**. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth.

Student's Name: _____ Date of Birth: ____/____/_____ Sex: ☐ M ☐ F

**Health Assessment**

**Date of Assessment:** ____/____/_____

Weight: _____lbs. Height: _____ ft. _____ in.

Body Mass Index (BMI): _____ BP_____

❑ Age / gender appropriate history completed

❑ Anticipatory guidance provided

**Physical Examination**

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

| | 1 | 2 | 3 | | 1 | 2 | 3 | | 1 | 2 | 3 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| HEENT | ☐ | ☐ | ☐ | Neurological | ☐ | ☐ | ☐ | Skin | ☐ | ☐ | ☐ |
| Lungs | ☐ | ☐ | ☐ | Abdomen | ☐ | ☐ | ☐ | Genital | ☐ | ☐ | ☐ |
| Heart | ☐ | ☐ | ☐ | Extremities | ☐ | ☐ | ☐ | Urinary | ☐ | ☐ | ☐ |

**TB Screening:** ☐ **No risk for TB infection identified** ☐ **No symptoms compatible with active TB disease**
☐ **Risk for TB infection or symptoms identified**
**Test for TB Infection: TST IGRA Date:_____ TST Reading _____mm TST/IGRA Result:** ☐ **Positive** ☐ **Negative**
**CXR required if positive test for TB infection or TB symptoms. CXR Date: _____** ☐ **Normal** ☐ **Abnormal**

**EPSDT Screens Required for Head Start – include specific results and date:**
Blood Lead:_____ Hct/Hgb_____

**Developmental Screen**

| *Assessed for:* | *Assessment Method:* | *Within normal* | *Concern identified:* | *Referred for Evaluation* |
|---|---|---|---|---|
| Emotional/Social | | | | |
| Problem Solving | | | | |
| Language/Communication | | | | |
| Fine Motor Skills | | | | |
| Gross Motor Skills | | | | |

**Hearing Screen**

❑ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.

| | 1000 | 2000 | 4000 |
|---|---|---|---|
| R | | | |
| L | | | |

❑ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Refer

☐ Referred to Audiologist/ENT ☐ **Unable to test – needs rescreen**

☐ Permanent Hearing Loss Previously identified: ___Left ___Right

☐ Hearing aid or other assistive device

**Vision Screen**

❑ With Corrective Lenses (check if yes)

| Stereopsis | ❑ Pass | ❑ Fail | | ❑ Not tested |
|---|---|---|---|---|
| Distance | Both | R | L | Test used: |
| | 20/ | 20/ | 20/ | |

❑ Pass ❑ Referred to eye doctor ❑ **Unable to test – needs rescreen**

**Dental Screen**

❑ Problem Identified: Referred for treatment

❑ No Problem: Referred for prevention

❑ No Referral: Already receiving dental care

**Recommendations to (Pre) School, Child Care, or Early Intervention Personnel**

**Summary of Findings** (check one):
☐ **Well child; no conditions identified of concern to school program activities**
☐ **Conditions identified that are important to schooling or physical activity** (complete sections below and/or explain here): _____

___ **Allergy** ☐ food: _____ ☐ insect: _____ ☐ medicine: _____ ☐ other: _____
Type of allergic reaction: ☐ anaphylaxis ☐ local reaction Response required: ☐ none ☐ epinephrine auto-injector ☐ other: _____

___**Individualized Health Care Plan needed** (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)

___ **Restricted Activity** Specify: _____

___ **Developmental Evaluation** ☐ Has IEP ☐ Further evaluation needed for: _____

___ **Medication.** Child takes medicine for specific health condition(s). ☐ Medication must be given and/or available at school.

___ **Special Diet** Specify: _____

___ **Special Needs** Specify: _____

**Other Comments:** _____

**Health Care Professional's Certification** (Write legibly or stamp) ☐ **By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

**Name:** _____ **Signature:** _____ Date: ____/____/_____

**Practice/Clinic Name:** _____ **Address:** _____

**Phone:** _____-_____-_____ **Fax:** _____-_____-_____ **Email:** _____

# 2020 - 2021 Student Calendar

**August**

| Su | Mo | Tu | We | Th | Fr | Sa |
|---|---|---|---|---|---|---|
| | | | | | | 1 |
| 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| 16 | 17 | 18 | 19 | 20 | 21 | 22 |
| 23 | 24 | 25 | 26 | 27 | 28 | 29 |
| 30 | 31 | | | | | |

**September**

| Su | Mo | Tu | We | Th | Fr | Sa |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 13 | 14 | 15 | 16 | 17 | 18 | 19 |
| 20 | 21 | 22 | 23 | 24 | 25 | 26 |
| 27 | 28 | 29 | 30 | | | |

**October**

| Su | Mo | Tu | We | Th | Fr | Sa |
|---|---|---|---|---|---|---|
| | | | | 1 | 2 | 3 |
| 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 11 | 12 | 13 | 14 | 15 | 16 | 17 |
| 18 | 19 | 20 | 21 | 22 | 23 | 24 |
| 25 | 26 | 27 | 28 | 29 | 30 | 31 |

**November**

| Su | Mo | Tu | We | Th | Fr | Sa |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | | | | | |

**December**

| Su | Mo | Tu | We | Th | Fr | Sa |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 13 | 14 | 15 | 16 | 17 | 18 | 19 |
| 20 | 21 | 22 | 23 | 24 | 25 | 26 |
| 27 | 28 | 29 | 30 | 31 | | |

**January**

| Su | Mo | Tu | We | Th | Fr | Sa |
|---|---|---|---|---|---|---|
| | | | | | 1 | 2 |
| 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| 24 | 25 | 26 | 27 | 28 | 29 | 30 |
| 31 | | | | | | |

**February**

| Su | Mo | Tu | We | Th | Fr | Sa |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 |
| 7 | 8 | 9 | 10 | 11 | 12 | 13 |
| 14 | 15 | 16 | 17 | 18 | 19 | 20 |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 |
| 28 | | | | | | |

**March**

| Su | Mo | Tu | We | Th | Fr | Sa |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 |
| 7 | 8 | 9 | 10 | 11 | 12 | 13 |
| 14 | 15 | 16 | 17 | 18 | 19 | 20 |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 |
| 28 | 29 | 30 | 31 | | | |

**April**

| Su | Mo | Tu | We | Th | Fr | Sa |
|---|---|---|---|---|---|---|
| | | | | 1 | 2 | 3 |
| 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 11 | 12 | 13 | 14 | 15 | 16 | 17 |
| 18 | 19 | 20 | 21 | 22 | 23 | 24 |
| 25 | 26 | 27 | 28 | 29 | 30 | |

**May**

| Su | Mo | Tu | We | Th | Fr | Sa |
|---|---|---|---|---|---|---|
| | | | | | | 1 |
| 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| 16 | 17 | 18 | 19 | 20 | 21 | 22 |
| 23 | 24 | 25 | 26 | 27 | 28 | 29 |
| 30 | 31 | | | | | |

**June**

| Su | Mo | Tu | We | Th | Fr | Sa |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 13 | 14 | 15 | 16 | 17 | 18 | 19 |
| 20 | 21 | 22 | 23 | 24 | 25 | 26 |
| 27 | 28 | 29 | 30 | | | |

**Calendar Legend**

- Orientation Days
- First/Last Day for Students
- No School
- Early Release / PD
- Christmas Break
- Spring Break
- Parent/Teacher Conferences


We have several ways you can see what's happening at Bethany Lutheran Preschool.

You can follow us on social media:

facebook.com/BLPreschool

@blps_tots

@BlpsTots

And now you can subscribe to Mobile Text Alerts!
We'll use this service for school cancellations, Rainy Day Dropoff, fundraising reminders, etc.

Text 'BLPS' to 662-200-4303 to begin receiving alerts
or go online at https://mobile-text-alerts.com/BLPS

Our new web address is www.BLPS-TOTS.com

You can also contact the Preschool Office via phone or email.
703.765.8687
preschool@bethany-lcms.org

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