ALPHABETLAND PRESCHOOL LLC

The registration deadline for all branches of Alphabetland Preschool LLCs will be Friday, **January 30th, 2026.** All registration with the $350.00 (registration + comprehensive fee) must be in by January 30th to be considered for acceptance. We are no longer on a "first come, first served" basis. You may either mail your application to our Waipahu office at 94-069 Waipahu Street, Waipahu, Hawaii 96797 or drop it off at any of our branches. Walk in registration must be in by 5:00 PM on January 30th, 2026. Check or money order should be made payable to Alphabetland Preschool LLC.

Applications received by 5:00 PM Friday, January 30th, 2026, will be accepted using the following priority list.

Priority List:

1) Transfer Students – Students who are currently attending Alphabetland, but would like to transfer to another branch for the new school year.
2) Siblings who currently attend or attended in the past.

Names	Date(s) attended	Branch

3) Alphabetland Preschool LLC (Newtown location only)
   Children must reside in Newtown to get prioity. Parents of Newtown applicants must be members of the Newtown Estates Community Association.

   Name of Parent______________________________

   Address______________________________

4) Alumni – Parent(s) who attended Alphabetland

   Name______________________________

   Date(s) attended
   Alphabetland____________________Branch____________________

After the priority applicants are accepted, a lottery will be held for the remaining available spaces. We will then inform you by mail if you have been accepted or not. Every effort will be made to process your application in a timely manner. **If we are unable to enroll your child, your registration + comprehensive fee will be refunded.**

Alphabetland Preschool LLC reserves the right to exercise sole discretion to resolve any errors or disputes.

Child's Name__________________________Waipahu___Pearl City___Newtown___

IMPORTANT: Please return this page with your application if applicable.

ALPHABETLAND PRESCHOOL LLC

Waipahu – Pearl City – Newtown

REGISTRATION PROCEDURES

1. Tuition and Child Care Fees:* **(Effective 08/03/26)** **MONTHLY FEES**

   A. Full Day 6:00 AM – 5:30 PM

		Ages 3 & 4*	Age 2**
(Waipahu & Pearl City Locations)	**One child**	**$1240.00**	**$1275.00**
(Newtown Location)		**1340.00**	
	Each additional child	**$100 off**	

   Tuition includes breakfast snack, lunch & afternoon snack.

   NOTE: Second child rate does not apply to those receiving tuition assistance.

   B. Late Charges - $3.00 per minute (based on school's clock) is charged for any child left beyond 5:30 PM. There will be no grace period. Late pickups after 6:00 PM will be charged $6.00 per minute. Late pickup is discouraged for health and safety reasons. This charge is payable when incurred. Repeated late pickups will necessitate disenrollment of the student to protect the school and its employees from liability.

   * This schedule of fees is subject to periodic change due to increases in Alphabetland Preschool LLC's costs.

   ** Alphabetland Preschool LLC accepts 2 year olds only at our Waipahu and Pearl City branches.

2. The registration + comprehensive fee of $350.00 per child must be paid with every registration form.
   NOTE: When enrollment is full and there are no immediate openings expected in the near future, the applicant may be placed on the waiting list without paying the registration + comprehensive fee.

3. Bring the completed application and the $350.00 registration + comprehensive fee to any of our branches or mail it to Alphabetland Preschool LLC, 94-069 Waipahu Street, Waipahu, Hawaii 96797.

4. Shortly after your application has been received, you will be notified of your child's acceptance. **Once accepted, your child is considered enrolled for the full calendar year. Thus, to withdraw from Alphabetland Preschool LLC, a 30 day written notice is required.** The comprehensive fee is for all books, paper, paste, crayons, scissors, etc. that Alphabetland Preschool LLC will provide throughout the school year.

_______ Initial

5. Registration fees and comprehensive fees, once accepted are considered to be earned and will not be refunded.

6. A. Although registration is for the full calendar year, Alphabetland Preschool LLC's tuition fees will be paid on a monthly basis. Tuition and child care payments are due and payable on the 1st day of each month in full. Accounts unpaid by the 5th day of each month are delinquent. Late payments made after the 10th day will be assessed a late fee of $50.00 and must be paid in cash or money order. Delinquent accounts after the 15th of the month will result in the student's disenrollment. Re-enrollment is then on a space available basis provided past due balances are paid.

   B. Registration to Alphabetland Preschool LLC holds your child's spot for the full calendar year according to the State of Hawaii licensing. Thus, monthly tuition is due unless 30 day written notice is given to Alphabetland Preschool LLC for withdrawal from school.

   C. A $20.00 charge will be assessed on all returned checks. Dishonored (bounced) checks may not be redeposited. Customers are asked to redeem bounced checks in cash or money order as soon as possible. If a dishonored check is not redeemed by the 10th of the month, an additional $50 late payment fee will be assessed.

   D. For the 2026-27 school year, the following per day rate will be used to calculate prorated tuition:

   (Waipahu & Pearl City): (3 & 4 Yr Olds) - $62.00 / day & (2 Yr Olds) –$64.00 / day
   (Newtown Location): (3 & 4 Yr Olds) - $67.00/ day

   E. **NO REFUNDS OR PRORATIONS WILL BE GIVEN FOR ABSENCES FROM ALPHABETLAND PRESCHOOL LLC. NO REFUNDS OR CREDITS WILL BE GIVEN FOR WITHDRAWALS UNLESS 30 DAYS WRITTEN NOTICE IS GIVEN. MAXIMUM REFUND OR CREDITS WILL BE AT THE RATE OF ½ THE MONTHLY CHARGE. NO REFUNDS OR CREDITS WILL BE GIVEN FOR SCHOOL HOLIDAYS OR VACATION PERIODS INCLUDING CHRISTMAS VACATION AND SPRING VACATION.**

   F. Students entering at times after the fifth (5th) of the month may have their initial month's tuition prorated. However, if the student's space is reserved or held, the full tuition will be due from the date the space is reserved.

   G. The summer session may be prorated with a proper 30 day written notice of a withdrawal date.

7. There will be no request for teachers. Children will be placed into classes by lottery in order to be fair to everyone.

____
Initial

8. Alphabetland Preschool LLC reserves the right to deny admission or to dismiss a child for any reason that we feel is in the best interest of the school including conflicts of interest, unresolved disputes, potential liabilities and confrontational disagreements. This is to ensure the protection of the health, welfare, and safety of the other children and school staff. Furthermore, Alphabetland Preschool LLC's shall have the right in its sole discretion to terminate the privilege of attendance of any student if the student, parent, guardian or other family associate engages in or exhibits abusive, rude, hostile, disruptive, aggressive, intimidating, annoying or harassing behavior. Any decision by Alphabetland Preschool LLC to dismiss a student shall be deemed final and non-appealable. Dismissal means immediate separation from the school.

9. Person(s) responsible for the tuition payment:______________________________
   NOTE: If person(s) responsible for the tuition payment is not the parent or guardian, please sign and date below.

______________________________ ____________________

Signature Date

____

Print Name

10. I have read the foregoing and hereby signify my acceptance of these policies by my signature below:

______________________________ ____________________

Parent's or Guardian's Signature Date

____

Print Name of Parent or Guardian

Sign and initial both copies. Attach 1 copy to your registration. Keep 1 copy for your information and records. Alphabetland Preschool LLC thanks you for your interest in our child care business.

For Office Use

Reg. Fee___________

Date ______________

ALPHABETLAND PRESCHOOL LLC

94-069 Waipahu Street Waipahu, HI 96797

REGISTRATION FORM 2026-27

Child's Name:_______________________________ Nickname:______________ Boy_____ Girl_____

Last First

Address:____ Phone:__________________

No. Street City Zip Code

Mailing Address: (If different from above)____

Date of Birth: _________________________ Place of Birth:__________________________________

****

Parent's Name: ____________________________________ Cell Number:_____________________

Home Address: ___________________________________ Home Number:____________________

Employer/Occupation: _____________________________ Bus. Number:_____________________

Business Address: _________________________________ Working Hrs: ___________ to___________

Parent's Name:____________________________________ Cell Number:_____________________

Home Address: ___________________________________ Home Number: ___________________

Employer/Occupation: _____________________________ Bus. Number:_____________________

Business Address: _________________________________ Working Hrs: ___________ to___________

Married _______ Single _______ Divorced _______ Separated _______ Widowed_______

If divorced, separated or single, who does the child live with? _________________________________

Who has legal custody? _______________________________________ (Please provide legal documents)

Email (Optional):____

Revised 1/26

Other schools attended: ____________________

Other sibling(s) who attended Alphabetland: ____________________

Other sibling(s) in the family:

Name	Age	School
1.		
2.		
3.		

****

Who will bring the child? ______________ Expected time of arrival each day: ______________

Who will pick up the child? ______________ Expected time of pick up each day: ______________

**** If either parent is not authorized to pick up, the school must be notified in writing ****

Persons authorized to pick up child other than parents: **(Must be at least 18 years old)**

Name	Address	Phone
1.		
2.		
3.		

****

Starting date: (example: Summer 6/01 or Fall 8/03)

____

Preferred location: (example: 1st choice, 2nd choice)

Waipahu ______________ Pearl City ______________ Newtown ______________

****

I am applying to Alphabetland Preschool LLC and hereby signify my acceptance of the registration procedure and registration form by my signature below:

____________________ Parent's or Guardian's Signature

____________________ Date

____________________ Print Name of Parent or Guardian

Revised 1/26

ALPHABETLAND PRESCHOOL LLC

94-069 Waipahu Street Waipahu, HI 96797

EMERGENCY FORM 2026-27

Student's Name:____
Last   First

Address:_________________________________ Telephone:________________

Emergency References: List two relatives, friends or neighbors who will assume temporary responsibility and care of your child if you cannot be reached.

1. Name:_________________________________ Cell#:________________
   Address:_________________________________ Bus.#:________________
   Relationship:_________________________________ Home#: ________________
2. Name:_________________________________ Cell#:________________
   Address:_________________________________ Bus.#:________________
   Relationship:_________________________________ Home#: ________________

Email (optional):_________________________________

****

Family Doctor:____

Address:____

Office Telephone:____________________ Physician's Exchange:____________________

****

Is your child allergic to any foods? **If "yes", list foods and please get a doctor's note for verification**

____

____

____

Does your child have any special medical problems? If "yes", please write a brief description and indicate if your child is receiving special medication(s).

____

____

____

****

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated above and to follow his/her instructions. If immediate attention is required, the school may make any arrangements deemed necessary.

_________________________________ ____________________

Signature of Parent or Guardian   Date

ALPHABETLAND PRESCHOOL LLC

94-069 Waipahu Street Waipahu, HI 96797

Waipahu *** Pearl City *** Newtown

CHECKLIST FOR SCHOOL

Name:____ Date____________________________

_______ Alphabetland Registration Sheet

_______ Emergency Information

_______ Health Form #14 - Available at your child's doctor's office. Your child will not be able to attend without this form.

_______ Form DHS 908 - Early Childhood Pre-K Health Record Supplement - Form available at the school

_______ 2 sets of extra change of clothing (including underwear) in a container (shoebox size) marked with your child's full name

_______ Painting smock

_______ Sleeping mat (blanket or towel acceptable). No slumber bags or bulky folding mats. Mats must be able to fit in cubby hole.

Please mark all clothing and child's belongings with full name.

If there are any changes in address or telephone numbers, please inform the office immediately.

Please make sure to fill out the "Permission to Participate in Program Activities and Receive Emergency Medical Care" form and the field trip permission slip as soon as your child starts school. Forms are available in the office or you can ask your child's teacher.

When all items on this checklist have been brought to school, please return this form to the office for filing.

When leaving the school, be sure to take all of your child's personal belongings with you. The health form may be picked up in the office. We will not be responsible for any items left.

IMPORTANT NOTICE!

By the ***FIRST DAY OF SCHOOL***, all new students to any public or private school in the State of Hawai'i must have:

1) Tuberculosis (TB) clearance

AND

2) A completed Student Health Record (Form 14) including a physical examination and all required immunizations ***OR*** a signed statement or appointment card from your child's doctor.

Students missing either of these requirements will ***NOT*** be permitted to enter school on the first day.

The Health State

Hawai'i Department of Health
Immunization Program

TB Document F: State of Hawaii TB Clearance Form

Hawaii State Department of Health
Tuberculosis Control Program

Patient Name	DOB	TB Screening Date

I have evaluated the individual named above using the process set out in the DOH TB Clearance Manual dated 2/10/17 and determined that the individual does not have TB disease as defined in section 11-164.2-2, Hawaii Administrative Rules.

Screening for schools, child care facilities or food handlers *(TB Document A or E)*
☐ Negative TB risk assessment
☐ Negative test for TB infection
☐ Positive test for TB infection, and negative chest X-ray

Initial Screening for health care facilities or residential care settings (*TB Document B or C)*
☐ Negative test for TB infection (2-step)
☐ New positive test for TB infection, and negative chest X-ray
☐ Previous positive test for TB infection, negative CXR within previous 12 months, and negative symptom screen
☐ Previous positive test for TB infection, and negative CXR

Annual Screening for Health care facilities or residential care settings (*TB Document D)*
☐ Negative test for TB infection
☐ New positive test for TB infection, and negative chest X-ray
☐ Previous positive test for TB infection, and negative symptoms screen
☐ Previous positive test for TB infection, and negative CXR

Signature or Unique Stamp of Practitioner: ______________________________

Printed Name of Practitioner: ______________________________

Healthcare Facility: ______________________________

This TB clearance provides a reasonable assurance that the individual listed on this form was free from tuberculosis disease at the time of the exam. This form does not imply any guarantee or protection from future tuberculosis risk for the individual listed.

Department of Education

STUDENT'S HEALTH RECORD

Student Address Label

Name ____
(Last) (First) (Middle Initial)

Female ☐
Male ☐

Preschool: Entry Date __/__/__
Elementary: Entry Date __/__/__
Intermediate/Middle: Entry Date __/__/__
High: Entry Date __/__/__

Birthdate ☐☐■☐☐■☐☐☐☐
Month Day Year

Parent's Name ______________________ ______________________
(Mother/Legal Guardian) (Father/Legal Guardian)

Allergies: ______________________

Please complete the following sections **(CHECK IF YES)**

MEDICAL STATUS

Allergy (type) ☐	Cancer/Leukemia ☐	Hearing Problems ☐	Hypertension ☐	Seizures ☐	Vision Problem ☐
Asthma ☐	Chronic Cough/Wheezing ☐	Heart Disease ☐	JRA Arthritis ☐	Sickle Cell Anemia ☐	
Behavioral Problems ☐	Diabetes ☐	Hemophilia ☐	Rheumatic Heart ☐	Skin Problems ☐	

PHYSICIAN'S EXAMINATION CODE: N-NORMAL; A-ABNORMAL; C-CORRECTED; R-RECEIVING CARE

Date	Grade	Height	Weight	BMI	Blood Pressure	Vision		Hearing		Eyes	Ears	Nose	Throat	Teeth	Heart	Lungs	Abdomen	Nervous System	Skin	Scoliosis	Extremities	Nutrition	Varicella Immunity Secondary to Disease (DATE)	Reviewed Immunization Record (Check if Yes)	Completed PPD Screening (Check if Yes) See Results Below	Provider's Signature	Provider's Stamp or Printed Name
						R.	L.	R.	L.																		
/ /																							/ /				
/ /																							/ /				

TUBERCULOSIS EVALUATION

Check one box below, complete date assessment, test or x-ray was administered.		Physician, APRN, PA, Clinic
☐ Negative TB Risk Assessment	Date: / /	
☐ Negative test for TB infection	Date: / /	
☐ Positive test, and negative chest x-ray	Date: / /	

DENTAL EXAMINATION

Dental Check-Up	Date: / /
Dental Check-Up	Date: / /

IMMUNIZATIONS (VACCINES, DATES GIVEN: MONTH/DAY/YEAR)

DTaP, DTP, DT, Tdap or Td	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Polio (IPV or OPV)	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Hib (*Haemophilus Influenzae* type b)	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Pneumococcal Conjugate	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Hepatitis B	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Hepatitis A	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
MMR	Type				Varicella Date		
	Date	/ /	/ /	/ /		/ /	/ /
HPV	Type				Meningococcal Conjugate Date		
	Date	/ /	/ /	/ /		/ /	/ /
Other	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /

Physician, APRN, PA or Clinic ______________________

Health History Comments: Include Referrals and Reports. Recommendation for significant findings.
(Please Print)

Date		Signature & Title	Date		Signature & Title

State of Hawaii
Department of Human Services

Benefit, Employment & Support Services Division

Early Childhood Pre-K Health Record Supplement*

Name of Child:			**Name of Child Care Facility:**
Child's DOB:			**To Be Completed By The Physician**
1. Type Screening	**2. Date Completed**	**3. Results**	**4. Recommendations/Follow up**
Head Circumference (up to 2yrs old)		☐ Normal ☐ Abnormal	
Hgb/Hct		☐ Normal ☐ Abnormal	
Lead		☐ Normal ☐ Abnormal	
BMI (≥ 2 years old)		☐ Normal ☐ Counsel	
Developmental Screening Tool: ☐ PEDS ☐ ASQ ☐ Other ______________		☐ No Concern ☐ Concern	

5. Medical Conditions	**6. Special Care Plan Needed**	**7. Recommendations**	**8. EC Provider Use Only**
Allergies/Sensitivities ☐ None • **List:**	☐ Yes ☐ No		☐ Special Care Plan completed
Medications/Treatments ☐ None • **List:**	☐ Yes ☐ No		☐ Special Care Plan completed
Special Diet prescribed by physician ☐ None • **List:**	☐ Yes ☐ No		☐ Special Care Plan completed
Behavioral Issues/Social Emotional Concerns ☐ None • **List:**	☐ Yes ☐ No		☐ Special Care Plan completed
Medical Conditions/Related Surgeries ☐ None • **List:**	☐ Yes ☐ No		☐ Special Care Plan completed

9. Physician/NP/APRN/PA or Clinic Name, Address, Zip, Phone, Fax	11. *I give my consent for my child's Health Care Provider to discuss the information on this form with my Early Childhood Provider* ______________________________ Early Childhood Provider Name
	12. Parent/Guardian Name
10. Physician/NP/ APRN/ PA or Clinic Signature (Signature or stamp) **Date**	**13. Parent/Guardian Signature** **Date**

*Supplement to the STATE OF HAWAI'I, DEPARTMENT OF EDUCATION, FORM 14, Rev. 2010, RS 09-1051 (Rev. of RS 06-0698)

Instructions for Completing the Early Childhood Pre-K Health Record Supplement

To Be Completed by the Physician (Please print)

1. Type of Screening: Check all that apply.
- **Head Circumference, Hgb/Hct, Lead, BMI**
- **Developmental Screening:** The screening tools listed are:
  - **PEDS:** Parent's Evaluation of Developmental Status
  - **ASQ:** Ages and Stages Questionnaire
  - **Other:** Print the name of screening tool used.

2. Date Completed
Write the date **mm/dd/year** the screening was performed. i.e., 06/01/2006.

3. Results
Mark (X) to indicate **"Normal"** or **"Abnormal", "No Concern"** or **"Concern", "Normal"** or **"Counsel".** If the box is marked abnormal, concern or counsel, please complete Box 4. Recommendations/Follow up.

4. Recommendations/Follow up
Please complete if abnormal, concern or counsel is selected.

5. Medical Conditions
Mark (X) **"None"** box for each item if the child has no **Allergies/Sensitivities, Medications/Treatments, Special Diet prescribed by physician, Behavioral Issues/Social Emotional Concerns, Medical Conditions/ Related Surgeries. List** type of medical condition, e.g., **Medical Condition/Related Surgeries List**: Asthma

6. Special Care Plan Needed
If child has a medical condition and the Early Childhood Provider should develop a special care plan, mark (X) **Yes**, next to the appropriate category. If child does not need a special care plan, mark (X) **No.**

7. Recommendations
Write your recommendations, e.g., "Medications must be administered by the parent before or after school hours."

8. Early Childhood Provider Use Only
This section is designated for the early childhood provider to complete if physician has marked (X) Yes in Box 6. Sample forms of the Special Care Plans can be requested from Department of Human Service (DHS) office, phone or downloaded from the Department of Human Service website.

9. Physician/NP/APRN/PA or Clinic Name
Type or print legibly physician, nurse practitioner, advanced practiced registered nurse, physician assistant or clinic name, address, zip, phone, and fax.

10. Physician/NP/ APRN/ PA, of Clinic (Signature or Stamp) and Date:
Physician, nurse practitioner, physician assistant must sign his/her name or stamp and write in the date of child's examination.

11. *"I give my consent for my child's Health Care Provider to discuss the information on this form with my Early Childhood provider."*
The Early Childhood program is encouraged to type, print legibly, or stamp the program name here prior to parent signature.

12. Parent/Guardian Name
Print the name of the Parent or Guardian

13. Parent/Guardian Signature
The Parent or Guardian must sign his/her name and write the date signed.

To be used as part of a cover letter to the preschool, parent or physician.

The purpose of the Hawaii Department of Human Services (DHS) Early Childhood Pre-K Health Record Supplement (EC-Pre-K HRS) is to provide developmentally appropriate information on the child's health, growth and developmental status for (Pre) school entry. The EC-Pre-K HRS is to be used in conjunction with the Hawaii Department of Education (DOE), Student's Health Record Form 14 2010.

The DHS EC Pre-K Health Record can be downloaded from the Hawaii Department of Human Services website, http://humanservices.hawaii.gov/ and search for Form 908. The DOE Student Health Record Form 14 can be downloaded at Department of Education website: http://www.hawaiipublicschools.org/Pages/home.aspx, click on Parents and Students, click on Enrolling in School, click on How to Enroll, look for Related Downloads and click on Student Health Record.

The child's physician is requested to complete the DOE Student Health Record Form 14 and DHS EC Pre-K Health Record Supplement. The following are directions for completing the DHS EC Pre-K Health Record Supplement.

SPECIAL CARE PLAN FOR A CHILD WITH ALLERGY

CHILD'S NAME:____________________________ Date of Birth: ___________

FACILITY NAME: ____

Parent(s) or Guardian(s) Name: ____

Emergency Phone Numbers: Mother _________________ Father _________________

Primary Health Provider Name: __________________ Emergency Phone: ___________

Specialist's Name (if any): ______________________ Emergency Phone: ___________

Description of Allergy: ____
____

Describe what signs/or symptom look like:_____________________________________
____

Describe known triggers: ____
____

Describe treatment:____
____

Possible side effects: i.e.: no peanut products allowed____________________________
____

Program modification: ____
____

When to call parent/health provider regarding symptoms or failure to respond to treatment:
____

When to consider what condition requires urgent care or reassessment: ______________
____

Physician's Name: ________________________________

Physician's Signature: ______________________________ Date: __________________