

**Registration Form for St. Michael's Preschool  
SCHOOL YEAR 2012-2013**

Name of Child \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male or Female (please circle one)

Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Parents' Names \_\_\_\_\_

Email Address(es) \_\_\_\_\_

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Please read the following questions and check all that apply.

Are you Catholic? \_\_\_\_\_ Non-Catholic? \_\_\_\_\_

What parish are you registered in? \_\_\_\_\_

For the following question please check only **one**. What is your child's ethnic background?

American Indian/Native Alaskan \_\_\_\_\_ Black \_\_\_\_\_

Asian \_\_\_\_\_

Hispanic \_\_\_\_\_

Native Hawaiian/Pacific Islander \_\_\_\_\_ Caucasian \_\_\_\_\_

Middle Eastern \_\_\_\_\_ Multi Racial \_\_\_\_\_

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**\*\*A registration fee of \$75.00 must accompany this application. This fee is non-refundable.\*\***

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**PLEASE CHECK THE CLASS YOU ARE INTERESTED IN:**

Morning Class (8:45 to 11:15)

Afternoon Class (12:30 to 3:00)

**MWF** \_\_\_\_\_

**MWF** \_\_\_\_\_

**TTH** \_\_\_\_\_

**TTH** \_\_\_\_\_

**MTWRF** \_\_\_\_\_

**MTWRF** \_\_\_\_\_

\*\*Please Note: Teachers are not assigned classrooms until summer

**\*\* DO NOT WRITE BELOW THIS LINE\*\***

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**FOR SCHOOL USE ONLY**

ASSIGNED CLASS SCHEDULE:

WAITLISTED FOR:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Paid Check # \_\_\_\_\_ / Cash \_\_\_\_\_ / Credit Card Number \_\_\_\_\_

Approved \_\_\_\_\_ Date \_\_\_\_\_

## EMERGENCY INFORMATION

### Section 1: General Information

Student Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Student Date of Birth \_\_\_\_\_ Male / Female (circle one)

Student Lives With \_\_\_\_\_ Home Phone \_\_\_\_\_

Student Address (include city and zip) \_\_\_\_\_

If Catholic, Parish Affiliation \_\_\_\_\_

In case of illness or emergency, who should be contacted first \_\_\_\_\_

### Mother/Guardian Information

Last Name \_\_\_\_\_ First \_\_\_\_\_

Home Address (if different from child's) \_\_\_\_\_

Place of Employment (include address) \_\_\_\_\_

Phone Numbers: Home (if different from child's) \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

E-mail address \_\_\_\_\_

### Father/Guardian Information

Last Name \_\_\_\_\_ First \_\_\_\_\_

Home Address (if different from child's) \_\_\_\_\_

Place of Employment (include address) \_\_\_\_\_

Phone Numbers: Home (if different from child's) \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

E-mail address \_\_\_\_\_

Name of child care person/center \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

### Section 11: Persons Authorized to pick up child *in addition* to Parents/Guardian

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Address (include city and zip) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Address (include city and zip) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Address (include city and zip) \_\_\_\_\_

## EMERGENCY INFORMATION

### Section III: Specific persons NOT authorized to pick up child

Please include a copy of appropriate court order or legal documentation

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

### Section IV: Emergency Contact Persons

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Address (include city and zip) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Address (include city and zip) \_\_\_\_\_

### Section V: Medical Information

Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

Doctor's Address (include city and zip) \_\_\_\_\_ Allergies: \_\_\_\_\_

Chronic Medical Condition(s) (e.g. diabetes, heart disease, contacts, hearing aids, asthma, epilepsy, etc.) \_\_\_\_\_

Medication(s) Student is Currently Taking \_\_\_\_\_

Is medication needed at school? Yes \_\_\_\_\_ No \_\_\_\_\_ Name of Medication \_\_\_\_\_

Hospital Preference \_\_\_\_\_

Hospital Address (include city and zip) \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone \_\_\_\_\_

Dentist's Address (include city and zip) \_\_\_\_\_

### Section VI: Medical Authorization

I give the school my permission to take my child to a hospital to receive emergency treatment. I hereby consent to any x-ray examination, medical or surgical diagnosis or treatment, and hospital care to be rendered to my child under the general or direct supervision and upon the advice of a physician and surgeon licensed under the provisions of the Medical Practice Act. I also consent to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered to my child by a dentist under the provisions of the Dental Practice Act. I authorize the medical facility to release my child into the custody of a school representative should hospital care no longer be needed. I understand that this is only in an extreme emergency and when the parent or legal guardian cannot be reached. I understand that I am responsible for any expenses incurred by the medical and/or dental diagnosis or treatment. I agree to pick up my child if he/she is sick or injured. If I cannot be reached the above emergency contacts can be called to pick up my child.

Parent or Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### Section VII: Student Records Update

I understand that I must keep my child's records up to date with current information

Parent or Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

St. Michael's Preschool Emergency Form

Child's Name: \_\_\_\_\_

Date of Birth: Address: \_\_\_\_\_

**1st person to contact:**

\_\_\_\_\_

\_\_\_\_\_

Mom's name & # \_\_\_\_\_

Dad's name & \_\_\_\_\_

**Additional pick-up person**

Name: \_\_\_\_\_

Number: \_\_\_\_\_

Sibling's Names:

\_\_\_\_\_

\_\_\_\_\_

Allergies:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# St. Michael the Archangel Preschool

## PERMISSION FORM

I hereby grant permission for my child to use all of the play equipment and participate in all of the activities of the school. YES \_\_\_\_\_ NO \_\_\_\_\_

I hereby grant permission for my child's name, parent's name, address and phone number to be included in the school directory. YES \_\_\_\_\_ NO \_\_\_\_\_

I hereby grant permission for my child to leave the school premises under the supervision of a staff member for neighborhood walks. YES \_\_\_\_\_ NO \_\_\_\_\_

I hereby grant permission for my child to be included in evaluations and pictures connected with the school program. YES \_\_\_\_\_ NO \_\_\_\_\_

I hereby grant permission for the Director or Acting Director to take whatever steps may be necessary to obtain emergency medical care if warranted. These steps may include but are not limited to the following:

1. Attempt to contact parent or guardian
2. Attempt to contact child's physician
3. Attempt to contact you through any of the person(s) listed on the emergency information form you completed for us.

If we cannot contact you or your child's physician we will do any or all of the following:

- Call another physician or paramedics
- Call an ambulance (will be accompanied by a staff member)

Any expenses incurred from the above actions will be borne by the child's family. YES \_\_\_\_\_ NO \_\_\_\_\_

***\*The school will not be responsible for anything that may happen as a result of false information given at the time of enrollment. Please see the Director to update the various forms if changes occur during the school year (ie new phone number or new address).***

***\*The school will not assume responsibility for a child who has not been signed in when he/she arrives for the day.***

I have read and understood all of the information included on this form.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Mother or Legal Guardian

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Father or Legal Guardian

***Child's Name*** \_\_\_\_\_  
***(Please print neatly)***

## Developmental Information

### ***Family History***

Child's Sibling(s)

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade in School \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade in School \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade in School \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade in School \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade in School \_\_\_\_\_

Other Members of the Household (include relationship and age)

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Pertinent Information You Would Like Your Child's Teacher To Know:

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Who has cared for the child other than parents (state whether adults or teenagers)?

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Has your child had any group play experiences? \_\_\_\_\_

Where? \_\_\_\_\_

Do you or your spouse have any special talents that you can share in the classroom, or with the teachers if needed? (i.e. occupations that might interest a child, playing a musical instrument, sewing, etc...)

### ***Developmental History***

Word child uses for urination? \_\_\_\_\_ Bowel Movements? \_\_\_\_\_

Dietary restrictions? \_\_\_\_\_

Favorite Indoor Activity? \_\_\_\_\_

Favorite Outdoor Activity? \_\_\_\_\_

Any special fears that you are aware of? \_\_\_\_\_

Any speech concerns? \_\_\_\_\_

Any other concerns? \_\_\_\_\_

Any surgeries (in or outpatient)? \_\_\_\_\_

How would you describe your child's personality? \_\_\_\_\_

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# GENERAL HEALTH APPRAISAL FORM

**PARENT please complete AND SIGN .**

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Allergies:  None or Describe \_\_\_\_\_  
Type of Reaction \_\_\_\_\_  
Diet:  Breast Fed  Formula \_\_\_\_\_  Age Appropriate  
 Special Diet \_\_\_\_\_  
Sleep: Your health care provider recommends that all infants less than 1 year of age be placed on their back for sleep.  
 Preventive creams/ointments/sunscreen may be applied as requested in writing by parent unless skin is broken or bleeding.  
I, \_\_\_\_\_ give consent for my child's care health provider, school child care or camp personnel to discuss my child's health concerns. My child's health provider may fax this form (& applicable attachments) to my child's school, child care or camp personnel. FAX #: \_\_\_\_\_ DATE: \_\_\_\_\_  
Parent/Guardian Signature \_\_\_\_\_

**HEALTH CARE PROVIDER:** Please Complete After Parent Section Completed

Date of Last Health Appraisal: \_\_\_\_\_ Weight @ Exam: \_\_\_\_\_  
Physical Exam:  Normal  Abnormal (Specify any physical abnormalities) \_\_\_\_\_  
Allergies:  None or Describe \_\_\_\_\_ Type of Reaction \_\_\_\_\_  
Significant Health Concerns:  Severe Allergies  Reactive Airway Disease  Asthma  Seizures  Diabetes  
 Hospitalizations  Developmental Delays  Behavior Concerns  Vision  Hearing  Dental  Nutrition   
Other Explain above concern (if necessary, include instructions to care providers): \_\_\_\_\_  
Current Medications/Special Diet:  None or Describe \_\_\_\_\_  
Separate medication authorization form is required for medications given in school, child care or camp  
For Fever Reducer or Pain Reliever (for 3 consecutive days without additional medical authorization)  
PLEASE CHOOSE ONE PRODUCT:  
 Acetaminophen (Tylenol) may be given for pain or fever over 102 degrees every 4 hours as needed Dose \_\_\_\_\_ or see the attached age-appropriate dosage schedule from our office  
OR  Ibuprofen (Motrin, Advil) may be given for pain or for fever over 102 degrees every 6 hours as needed Dose \_\_\_\_\_ or see the attached age-appropriate dosage schedule from our office  
Immunizations:  Up-to-Date  See attached immunization record  Administered today:

**Health Care Provider: Complete if Appropriate**

**\*\*ONLY REQUIRED BY EARLY HEAD START AND HEAD START PROGRAMS PER STATE EPSDT SCHEDULE\*\* \*\***  
Height @ Exam \_\_\_\_\_ \*\* B/P \_\_\_\_\_ \*\* Head Circumference (up to 12 months) \_\_\_\_\_ \*\*  
\*\* HCT/HGB \_\_\_\_\_ \*\* Lead Level  Not at risk or Level \_\_\_\_\_  
\*\*TB  Not at risk or Test Results  Normal  Abnormal  
\*\*Screenings Performed:  Vision:  Normal  Abnormal  Hearing:  Normal  Abnormal  Dental:  Normal  
 Abnormal Recommended Follow-up \_\_\_\_\_

**Provider Signature**

Next Well Visit:  Per AAP guidelines\* or  Age \_\_\_\_\_  
This child is healthy and may participate in all routine activities in school sports, child care or camp program. Any concerns or exceptions are identified on this form.  
\_\_\_\_\_  
Signature of Health Care Provider (certifying form was reviewed) Date: \_\_\_\_\_

Office Stamp  
Or write Name, Address, Phone,\*

**POPS Apparel OrderForm**  
*Make checks payable to POPS*

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

	<b>Size</b> (Please circle)	<b>Quantity</b>	<b>Price</b>	<b>Total</b>
Adult T-Shirt (Male/Regular)	S    M    L    XL    XXL		\$15-\$17	
Adult T-Shirt (Female/Scoop Neck)	S    M    L    XL    XXL		\$25	
Youth T-Shirt	2T   3T    4T   5T    YS    YM		\$12	
Adult Hoodie	S            M    L    XL    2XL		\$25-\$27	
Youth/Toddler Hoodie	2T 3T    4T    S (6-8) M(10-12) L (14-16) XL (18-20)		\$20	
HatI	One Size		\$12	
Cinch Backpack	One Size		\$12	