

**Registration Form for St. Michael's Preschool
SCHOOL YEAR 2010-2011**

Name of Child _____

Date of Birth _____ Male or Female _____

Address _____

City _____ Zip _____ Phone _____

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 _____

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

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****

FOR SCHOOL USE ONLY

ASSIGNED CLASS SCHEDULE:

WAITLISTED FOR:

Paid Check # _____ / Cash _____ / Credit Card Number _____

Approved _____ Date _____

ST. MICHAEL'S PRESCHOOL
HEALTH STATUS FOR ENROLLMENT FORM

Children who enroll in child care programs must submit a signed and dated statement of the child's current health status which indicates the child's abilities and/or limitations to participate in a regularly scheduled program of play in a group of young children. This report is to be filled out by a licensed physician of a licensed nurse practitioner who has seen the child in the last twelve months.

Health Record For: St. Michael's Preschool Program

Child's Name _____ Sex _____ Birth Date _____

Address _____

Past Illnesses *Indicate those that the child has had by giving the approximate date

Chicken Pox _____	Rubeola _____	Rubella _____
Rheumatic Fever _____	Asthma _____	Hay Fever _____
Diabetes _____	Mumps _____	Epilepsy _____
Whooping Cough _____	Polio _____	Other _____

This child is _____ is not _____ physically or emotionally able to participate in the day care program named above.

Comments: _____

Surgery/Accidents/Illnesses/Chronic or Handicapping Problems _____

Describe any physical condition(s) requiring special attention by the preschool staff _____

Medications prescribed _____

Any known allergies (drug or otherwise) _____

Prescribed routine for treatment of allergies _____

Vision _____ Hearing _____

Please provide a record of the immunizations and the date they were administered on the Colorado Department of Health Certificate of Immunization and attach to this form.

Date of the most recent examination of this child _____

Signature of the physician or nurse practitioner _____

Please print the name and address of the physician or nurse practitioner _____

SECTION I: GENERAL INFORMATION

Teacher _____

Room Number _____

Student Name Last _____ First _____ Middle _____

Student Date of Birth _____ Male _____ Female _____

Student Lives With _____ Home Phone Number _____

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 (include city and zip) _____

Place of Employment (include address) _____

Phone Numbers Home _____ Work _____ Cell _____

E-mail address _____

Father/Guardian Information

Last Name _____ First _____

Home Address (include city and zip) _____

Place of Employment (include address) _____

Phone Numbers Home _____ Work _____ Cell _____

E-mail address _____

Student lives with

(If your child is picked up after school by a day care center or a permanent babysitter, please indicate this information below)

Name of child care person/center _____

Address _____ Phone _____

SECTION II: PERSONS AUTHORIZED TO PICK UP CHILD (INCLUDING PARENTS/GUARDIAN)

(Under no circumstances will the child be released to anyone not known to the school without written authorization from the parents/legal guardian)

Name Last _____ First _____ Relationship _____

Phone Home _____ Work _____ Cell _____

Address (include city and zip) _____

Name Last _____ First _____ Relationship _____

Phone Home _____ Work _____ Cell _____

Address (include city and zip) _____

Name Last _____ First _____ Relationship _____

Phone Home _____ Work _____ Cell _____

Address (include city and zip) _____

Please Print

EMERGENCY INFORMATION

Please Print

SECTION III: SPECIFIC PERSONS NOT AUTHORIZED TO PICK UP CHILD

Please include a copy of appropriate court order or legal documentation)

Name Last	_____	First	_____	Relationship	_____
Name Last	_____	First	_____	Relationship	_____
Name Last	_____	First	_____	Relationship	_____

SECTION IV: EMERGENCY CONTACT PERSONS

Other than parents/guardians)

Name Last	_____	First	_____	Relationship	_____
Phone Home	_____	Work	_____	Cell	_____
Address (include city and zip)	_____				

Name Last	_____	First	_____	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 Conditions(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 _____
(If yes, complete the medication form located in the school handbook)

Hospital Preference Name _____ City _____

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.

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's Signature _____ Date _____

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)

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

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

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)? _____

What method of behavior control is used at home? _____

How would you describe your child's personality? _____