



2024-25 Registration Form

Child's Name _____

Address _____
Street City Zip

Telephone Number _____ Birthday ____/____/____ Sex: M F

E-mail _____

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Circle Class Choice

2 Year Playgroup: Option #1 MW 9:00 – 11:30 a.m.

3 Year Old Class: Option #1 TTH 9:00 – 11:30 a.m.

Pre-K Class: Option #1 MW OR Option #2 MWF 9:00 – 11:30 a.m.

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Parent Information

Mom's Name _____

Dad's Name _____

Parents are: _____ both at home _____ live separately

Family Information

Names and Ages of Siblings _____

Emergency Contact Information (other than parents)

Name _____

Address _____

Phone _____ Alternate Phone _____

Relationship to Student _____

List anyone who may NOT have contact with your child

Immunization Records -- Please provide us with a copy of your child's records from his/her physician.

The following immunizations are recommended by the CDC.

Hepatitis B	Rotavirus	DTaP	Hib	Pneumococcal
IPV	MMR	Varicella	Hepatitis A	Yearly Influenza

Medical Information

List all allergies (foods, medicines, etc.) _____

List any medical conditions _____

List all medications taken on a regular basis _____

Is the child potty trained? YES NO IN PROCESS

List any concerns with toilet training _____

List any emotional concerns _____

List any speech or hearing concerns _____

Physician Information

If you or your emergency contact cannot be reached in case of a medical/dental emergency, we will contact the medical center of your choice, or call 911 if necessary. Please fill in the following information and sign below to give us permission to do so.

Physician's Name _____

Address _____

Phone _____

Dentist's Name _____

Address _____

Phone _____

Hospital Preference _____

Parent Signature _____ Date _____

Additional Information

Please list any information that you feel will be helpful to the teacher.

