

General Information

Child's Name _____ Nick Name _____

How would you like your child to learn to write their name? _____

Birthdate: _____ Male _____ Female _____

Address: _____ Phone _____
Street City Zip

Father's Name: _____ Address: _____

Phone: _____

Place of Employment: _____ Phone _____

Mother's Name: _____ Address: _____

Phone: _____

Place of Employment: _____ Phone _____

Child's Physician: _____ Dentist: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Persons to be called in case of an emergency if parents cannot be reached and are authorized to pick up the child:

Name: _____ Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Other persons authorized to take the child from the preschool facility:

Name: _____ Name: _____ Name: _____

Phone: _____ Phone: _____ Phone: _____

Other Children in the family:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Has your child had previous group experience? Yes No If yes, where?

Parent or Guardian's Authorization:

In the event of an accidental ingestion, I understand that staff will contact the Poison Control Center. I give permission for the staff to administer Syrup of Ipecac to my child, _____, if directed to do so by the authorities at Poison Control.

Signature of Parent or Guardian: _____ Date: _____

For Staff Use Only

Hours and days child attends this center: _____

Attended Pre-enrollment Fall Conference: _____ Date: _____

Date of Parent / Teacher Conferences: Fall _____

Spring _____