St. Michael's Preschool

Registration Checklist

Parents wishing to enroll their child(ren) in St. Michael's Preschool must complete the following documents and submit them to the school office by August 1st, 2019:

Required:

FORMS:

- Emergency Information
- Permission Form
- Developmental Information
- General Health Appraisal Form

  (to be completed by healthcare provider)
- Immunization Record or Waiver
- Tuition Contract – this will be provided to you after the registration fee is paid

FEE:

- Registration Fee of $150 due upon registration

Registration forms and documents may be mailed or turned into the office.

Questions? Contact the Director at 303-690-6797, ext 323 or d.toby@comcast.net

Registration Form for St. Michael's Preschool

SCHOOL YEAR 2019-2020

***if completed online, you do not need to fill out again**

Name of Child_____

Date of Birth_____ Male Female

Address_____

City_____Zip_____Phone_____Cell Phone_____

Parents' Names_____

Email Address(es)_____

Are you Catholic? Yes _____ No _____

If yes, in which parish are you registered?_____

Please fill in <u>both</u> a race and ethnicity (used for Archdiocesan Demographic Reporting only):

<u>Race of Student (Select One)</u>:

American Indian/Native Alaskan___ Black/African American___ Native Hawaiian/Pacific Islander_____

Asian ____ White (Including Middle Eastern Countries)_____ Multi-Racial (two or more races)_____

<u>Ethnicity (Select One):</u> Hispanic/Latino_____ Non-Hispanic/Latino_____

Has your child ever been diagnosed with, or screened for learning disabilities? YES NO

If yes, please provide the results of the testing

_____

_____

Are you interested in applying for financial aid? YES NO

A registration fee of $150 must accompany this application. This fee is non-refundable

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PLEASE CHECK THE CLASS YOU ARE INTERESTED IN:

<u>Morning Class (8:45 to 11:15)</u>	*<u>Afternoon Class (12:30 to 3:00)</u>*	*<u>Full Day Class (8:45 to 3:00)</u>*
MWF_____	**MWF**_____	**MWF**_____
TTH_____	**TTH**_____	**TTH**_____
MTWRF_____	**MTWRF**_____	**MTWRF**_____

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

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

FOR SCHOOL USE ONLY

ASSIGNED CLASS SCHEDULE:_____

Date Registration Form Received: _____

Registration Fee:_____Date:_____

Paid Check #_____/ Cash_____/ Credit Card_____

Approved_____Date_____

EMERGENCY INFORMATION, page 1

Section I: 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 _____

Section II: Persons authorized to pick up child *in addition* to Parents/Guardian (MUST INCLUDE AT LEAST ONE)

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, page 2

Child Care Provider

Name of child care person/center _____

Address _____

Phone _____

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 Person(s) (other than parents). Must list at least one.

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 (ALL FIELDS ARE REQUIRED)

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 (must choose one) _____

Hospital Address (include city and zip) _____

Medical Insurance Company _____ Policy Number _____

Dentist's Name _____ Phone _____

Dentist's Address (include city and zip) _____

Child's Name: _____

Section VI: Medical Authorization

I give St. Michael's Preschool 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: _____

Mom's name and Phone # _____

_____

Dad's name and Phone # _____

_____

Address: _____

_____

1st person to contact:

_____

Additional pick-up person

Name: _____

Number: _____

Allergies/Medical Issues:

_____

_____

Word for Bathroom:

_____

_____

Sibling's Names:

_____

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 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 (i.e. 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

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)?_____

How would you describe your child's personality?_____

_____

GENERAL HEALTH APPRAISAL FORM

PARENT please complete AND SIGN the top portion ONLY.

Child's Name:_____Birth date:_____
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 he 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_____

HEATH 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 ❑Nat 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: O 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,*

The Colorado Chapter of the American Academy of Pediatrics (AAP) and Healthy Child Care Colorado have approved this form. 04/07
*The AAP recommends that children from 0-12 years have health appraisal visits at: 2, 4, 6, 9, 12;15, 18 and 24 months, and age 3, 4, 5, 6, 8, 10 and 12 years.