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, 2017:

Required:

FORMS:

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

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

DOCUMENTS:

- Immunization Record or Waiver

FEE:

- Registration Fee of $150

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 2017-2018

***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

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:____

Sibling's Names:

____

Allergies/Medical Issues:

____

____

Word for Bathroom:

____

____

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

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...)

____

<u>Developmental History</u>

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.
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