

Preschool(s) previously attended: _____

Please check any of the following if applicable:

Adopted_____ Youngest Child_____ Oldest Child_____ Only Child_____

Twins_____ Physically Challenged_____ Special Emotional Needs_____

- Number of children in the family:
- List ages and sex of each:
- Do any relatives or others live with the family?
- If yes, explain who and the relationship to the family: .
- What are your child's strengths and weaknesses:
- What is the primary language spoken at home:
- If your child has been enrolled in another preschool program and you have chosen not to continue in the program, please give your reasons:
- List any special need(s) that we should be aware of:
- List any allergies your child has:
- Is your child on any continuing medication?

- What are some of your child's favorite activities or special interests?
- What are some of your child's favorite stories and songs?
- What are your child's favorite foods? Are there any special food considerations about which we ought to know including allergies?
- Who are the important people in your child's life outside of his immediate family (special friends, caregivers, etc)? What pets do you have?
- What special dislikes or fears does your child have?
- What special routines, if any, do you use with your child when he or she is having a rough time, or when you are leaving? Does your child have a special teddy bear, blanket, or other transitional object?
- Is there anything else that you think would be helpful or important for the staff to know about your child before school starts?
- Which holidays are celebrated in your home?

EMERGENCY INFORMATION

PLEASE ATTACH A COPY OF YOUR CHILD'S CURRENT SHOT HISTORY

Child's Name: _____

Emergency Contacts Other Than Parents

Name _____

Street Address _____

Relationship _____ Phone _____

Name _____

Street Address _____

Relationship _____ Phone _____

Medical Emergency Information

Name of family doctor or medical facility to call in case of emergency:

_____ Telephone _____

I give my permission for medical

transportation _____(yes) _____(no) _____

(Signature & Date)

treatment _____(yes) _____(no) _____

(Signature & Date)

AUTHORIZATION FOR CHILD PICK-UP

These People May Pick Up My Child

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

I certify that the information contained in this application is true and complete.

Signature: _____

Printed Name: _____

Date: _____

I certify that the information contained in this application is true and complete.

Signature: _____

Printed Name: _____

Date: _____

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Signature: _____

Printed Name: _____

Date: _____

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