

Little Lights Christian Preschool and Early Childhood Education Center

5/2015

Child's Name: _____
(last) (first) (middle) (nickname)

Birth date: _____ Church Affiliation: _____

Full Address: _____ Home Telephone: _____

Father's Name: _____ Occupation: _____

Work phone: _____ Cell #: _____

Mother's Name: _____ Occupation: _____

Work phone: _____ Cell #: _____

Names & Relationships to child, of others in home (include other children, adults and pets, listing ages of children) _____

In case of emergency, who can be contacted and allowed to pick up your child if parents cannot be reached? (mandatory)

Name: _____ **Address:** _____

Telephone: _____ **Relationship :** _____

Name: _____ **Address :** _____

Telephone: _____ **Relationship:** _____

Primary Doctor's Name, Address & Phone #: _____

Dentist's Name, Address, & Phone # : _____

List health information that should be known by the teacher (allergies, vision or hearing problems, activity restrictions, regular medication, etc.): _____

Has your child had any illnesses, operation, accidents or hospital experiences, and what were your child's reactions to these experiences? _____

Children who have special health care needs are those who have chronic physical, developmental, behavioral or emotional conditions expected to last 12 months or more and who require health and related services of a type beyond that required by children generally. If your child does have special health care needs please discuss these with the School's Director.

I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, and the Office of Children and Family Services regulations under which it operates. **YES** **NO**

I understand that in the event I cannot be reached, I am consenting to and authorizing the physician, dentist or hospital selected by Little Lights Christian Preschool and Early Childhood Education Center to secure proper medical, dental, surgical care and/or hospitalization that may be in the judgment of the dentist, doctor and/or hospital, advisable or necessary at the time for my child. **YES** **NO**

I have provided information on my child's special needs (Allergies, Diet, Disabilities, and/or Medical Information) to the school, as may be necessary to assist the school in properly caring for my child in case of emergency. **YES** **NO**

I agree to review and update this information whenever a change occurs and at least once every six months.
[] YES [] NO

SIGNATURE- PARENT OR PERSON(S) LEGALLY RESPONSIBLE

DATE

Which hand does your child prefer? Left _____ Right _____ Not sure _____

Please circle the terms that best describes your child:

Happy Aggressive Even-Tempered Moody Awkward Imaginative

Dependant Stubborn Impulsive Fearful Shy Sympathetic

What methods of discipline have you found to be most effective? _____

How does your child react to correction? _____

In separating from you, how does your child react? _____

Has your child any fears of which others should be aware? _____

PLAY INFORMATION:

What activities does your child enjoy? Include favorite toys, stories, and imaginary playmates. _____

What age and gender are your child's most frequent companions? _____

How does your child interact with other children? _____

PREVIOUS SCHOOL EXPERIENCES:

Has your child attended another Preschool or other organized activity? (Ex. Library, Story Hour, Speech, Mommy & Me) _____

How did you hear about our Preschool? Please be specific. _____

OTHER INFORMATION:

What would you like your child to gain from their Preschool experience? _____

ADDITIONAL INFORMATION: such as adoptions, separations, divorce*, illness, death which might be helpful to us in caring for your child. _____

In cases of divorce/separation please explain custody and visiting arrangements and provide supporting documentation where necessary _____

ALL INFORMATION SHARED WITH US IS KEPT IN COMPLETE CONFIDENCE.