St. Thomas the Apostle Preschool
Registration Form

Student Name:_____ _____ ____ _____
Last First M.I. Date of Birth Age Social Security #

1) Parent/Guardian: _____ Email: _____
Address:_____ Phone:_____
Employment: _____ Phone: _____
Other Info Needed: _____

2) Parent/Guardian: _____ Email: _____
Address:_____ Phone:_____
Employment: _____ Phone: _____
Other Info Needed: _____

I am registered in _____Parish

Proof of Guardianship: If there is a custody agreement, attach the portion of the agreement that stipulates custody and any other information pertinent for the school, to the registration form. This is a condition of enrollment. If there is a change in the agreement notify the school immediately.

Attention New Students: Parents, please attach a copy of your son/daughter's **birth certificate and health immunization record. *If he/she is Catholic, please attach a copy of his/her baptismal record.**

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Name of Persons authorized to pick up your child:

1._____ Phone_____

2._____ Phone_____

3._____ Phone_____

If plans change and someone other than those listed above will be picking your child up pleased notify the teacher/office, in writing if possible, or with a phone call.

Approximate time your child will be dropped off _____

Approximate time your child will be picked up _____

If part time, please list days your child will attend_____

St. Thomas the Apostle Preschool
MEDICAL Form

PERSONS TO CONTACT IF PARENTS ARE NOT AVAILABLE

1) NAME:_____ RELATION:_____ PHONE:_____
2) NAME:_____ RELATION:_____ PHONE:_____
3) NAME:_____ RELATION:_____ PHONE:_____
3) NAME:_____ RELATION:_____ PHONE:_____

MEDICAL INFORMATION

FAMILY DOCTOR:_____ PHONE:_____
FAMILY DENTIST:_____ PHONE:_____
PREFERRED HOSPITAL:_____ PHONE:_____
HEALTH INSURANCE: (CHECK)
PRIVATE/GROUP_____ MEDICAID_____ NO HEALTH INSURANCE _____

HEALTH INFORMATION

LIST ANY HEALTH CONDTIONS OR DISABILITIES: _____

_____

LIST ANY MEDICATIONS YOUR CHILD IS ALLERGIC TO:_____

_____

OTHER ALLERGIES:_____

_____

_____

_____

MEDICATIONS TAKEN ROUTINELY: _____
MEDICATIONS TAKEN AS NEEDED: _____
ANY VISION/HEARING PROBLEMS? YES/NO (WEARS GLASSES, CONTACTS, HEARING AID)
EXPLAIN: _____
CHILD HAS HAD A PHYSICAL EXAM IN THE LAST TWO YEARS? YES/NO
CHILD HAS HAD A DENTAL EXAM IN THE LAST TWO YEARS? YES/NO

THE SCHOOL IS REQUIRED TO HAVE CURRENT AND COMPLETE IMMUNIZATION RECORD ON EACH CHILD BY THE FIRST DAY OF SCHOOL.

The school will never dispense internal medication at the request of a student. **NO ASPRIIN/TYENOL WILL BE DISPENSED.** In response to parental request, the school will arrange the medicine which is clearly labeled, be stores, and dispensed by a responsible adult. Often this request is a temporary one. If you wish to request on a regular basis, please explain: _____

_____

The school will assist students who have minor accidents or aliments, by using ordinary external supplies such as bandages, antiseptic solution, adhesive tape, cold packs, etc. If you **DO NOT** wish any of these supplies used for your child, please explain: _____

_____

**Financial assistance is available, for those who qualify, for dental and/or eye care, shoes, and immunizations. If you would like more information on this, please contact the school principal. **

**Vision and hearing screening will be made annually. **

AUTHORIZATION FOR SCHOOL OFFICIALS IN CASE OF EMERGANCY:

I authorize school officials to secure emergency treatment if I cannot be reached. I will assume responsibility for expenses incurred.

DATE:_____ PARENT SIGNATURE:_____