

St. George's Kindergarten & Mothers Day Out
ENROLLMENT/HEALTH RECORD
2011-12
(Please Print)

CHILD INFORMATION:

Student's Name _____ M _____ F _____
FIRST MIDDLE LAST

Child likes to be called _____

Date of Birth _____ Age as of September 1, 2011 _____ (years/months)

Place of Birth _____ (country)

PARENT INFORMATION:

MOTHER: Dr. _____ Mrs. _____ Ms. _____
 Name: _____

FATHER: Dr. _____ Mr. _____
 Name: _____

Address: _____

Address: _____

Phone: Home _____ Cell _____ Work _____

Phone: Home _____ Cell _____ Work _____

E-mail: _____

E-mail: _____

Where employed: _____

Where employed: _____

Occupation: _____

Occupation: _____

Custodial Parent if divorced _____ (Provide a copy of Custody Order) YES _____ NO _____

Other children and members of the family:	Date of Birth	Place of School/Work
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pets _____ Name/s _____

Type _____

Does your child have a close family relative or friend they may refer to?

Name _____ Relationship _____

Will your child attend another program while enrolled at St. George's? yes _____ no _____

If so where? _____

Grandparents' Name and Address: **PLEASE PRINT Information used for mailings please include full address**

Name(s) _____ Name(s) _____

Address _____ Address _____

_____ zip _____

_____ zip _____

(PLEASE COMPLETE 3 PAGES)

Persons authorized to pick up and transport child other than parent or custodian: (Give full name and telephone number of the person to whom the child may be released. They must be listed below to ensure the child's safety.

Name(s) _____ Home Phone: _____ Cell Phone: _____
Name(s) _____ Home Phone: _____ Cell Phone: _____
Name(s) _____ Home Phone: _____ Cell Phone: _____

I give permission for my child's photograph to be used in school newsletter, yearbook, church/school website: YES _____ NO _____

EMERGENCY INFORMATION:

Physician Name: _____ Office Phone: _____
Medical Association/Address: _____

Are there any written doctor's instructions for care/medical treatment for this child given to St. George's: YES _____ NO _____
Does this child have any food, environmental and/or medical allergies? YES _____ NO _____
Explain any allergies and treatment thereof: _____

Name of person(s) and phone numbers, other than the childcare staff, authorized to act for parent in an emergency:

Name _____ Home Phone: _____ Work: _____ Cell: _____
Name _____ Home Phone: _____ Work: _____ Cell: _____

If parents/physicians, or person(s) named above are not available in an emergency requiring immediate medical attention, do you authorize the school:

- (a) to seek treatment from a physician selected by the school? YES _____ NO _____
- (b) to exercise emergency medical care? YES _____ NO _____

In such an event, which hospital facilities would you prefer the school to use? _____

It is understood that your child is to be kept at home if she/he is unable to take part in regular daily school activities, including outside play. After an illness your child should not return to school until they have been free of fever, vomiting, and diarrhea for at least 24 hours, without the benefit of medication.

We do not administer medications except for allergic emergencies. A medication release form must be completed and on file in the Business Office.

DEVELOPMENTAL HEALTH HISTORY:

Physical: The following information is confidential and will be kept for use by those working with your child.

Does your child have any physical limitations? Speaking _____ Running _____ Seeing _____ Hearing _____ Fine Motor _____
Sitting Still _____ Other _____

Explain _____

Is your child currently receiving services for: Speech _____ Hearing _____ RIP Therapy _____

Occupational Therapy _____ Physical Therapy _____ Other _____

Explain _____

Does your child have allergies? _____

Explain _____

Has your child had any health problems in the past? _____

Now ? _____ Explain _____

Does your child take medications regularly? _____ What and When _____

St. George's Kindergarten recommends a yearly vision and hearing screening during your child's annual Doctors visit.

Date of last vision and hearing screening _____

Does your child have any recurring chronic illness or health problems such as:

asthma _____ cerebral palsy _____ developmental delay _____ seizure disorder _____

diabetes _____ frequent earaches _____ hemophilia _____ other _____

If medically diagnosed, what is the name of the doctor who diagnosed the illness or health problem? _____

Do you have other concerns about your child's health? _____

Is your child on any special diet? Please explain _____

Social Relationships/Play:

Is your child: friendly _____ aggressive _____ shy _____ withdrawn _____

Does your child play well alone? _____

What is you child's favorite toy? _____ What does your child call it? _____

Is your child frightened by (check any that apply):

animals _____ fire drills _____ loud noises _____ the dark _____ storms _____ other _____

How do you discipline your child? (Check all that apply) Behavior Modification Chart _____ Diversion _____ Spanking _____

Taking something way _____ Time Out _____ Redirect _____ Other _____

Explain _____

Does your child use an item for comfort? _____ What? _____ What does he call it? _____

Is there any other information that you wish to share that would assist us in meeting your child's needs?

ACKNOWLEDGMENT

I understand any changes in the above information must be entered immediately and initialed.

The above information is true and accurate to the best of my knowledge.

SIGNATURE OF PARENT(S) OR CUSTODIAN(S)

DATE