IMMACULATE CONCEPTION
PRESCHOOL

Registration Form

One Year T/T ____(9am-12pm) M/W/F _____(9am-12pm)
Two Year T/T ____(9am-12pm) M/W/F _____ (9am-12pm)
**** Students enrolling for 3 years or older must be toilet trained****
Three Year T/T ____ M/W/F _____ M - F ____ (9am-2pm)
Four Year PreK T/T ____ M/W/F _____ (9am-2pm)
Four Year PreK I M-F _____(9am-2pm)
Four Year PreK II M-F _____(9am-2pm)
*Four/Five Year PreK III M-F_____ (9am-2pm)
Must be 5 years by December 31, 2023

Male _____ Female _____ Child's Birthday _____
Child's Full Name _____
What is the child called? _____
Is your child new to this school? Yes _____ No _____

Parents Information:

Mother's Name _____ Contact# _____
Mailing Address _____ Work # _____
City/State _____ Zip _____ Other # _____
Where Employed _____E-Mail _____
Hours _____
Father's Name _____ Contact # _____
Mailing Address _____ Work # _____
City/State _____ Zip _____ Other # _____
Where Employed _____E-Mail _____
Hours _____
Marital Status oMarried o Divorced o Single o Widowed
If divorced who is the primary caregiver o Father o Mother
o Joint Custody o Grandparents

Emergency Information:

Name of person(s) authorized to act for parent in an emergency
_____Phone _____
_____Phone _____
Name of person to provide transportation _____
Name of Physician _____ Phone _____
Religious Affiliation _____

Background Information:

Other children in the family: Name Birthday School

_____

_____

Registration Fee: $100.00

- ☐ Check or Cash
- ☐ Bill to my Brightwheel account

Immaculate Conception Preschool
Student Health History & Emergency Medical Release

Student's Name _____ Class_____

Please let us know your child's health needs by completing this form.

____My child has no health problems which would affect his/her school day.

____My child's health needs include the conditions marked (X).

___Allergies, please list_____

What happens?_____

Is EpiPen Prescribed? __Yes __No (If yes parent provide EpiPen)

___Asthma Is inhaler used? __Yes __No If yes, how often?_____

What medications are taken for Asthma?_____

___Diabetes What medications are taken?_____

Any special procedures during the school day?_____

___Hearing problems, please describe_____

___Vision problems Glasses? __Yes __No Contacts? __Yes __No

___ADD or ADHD Diagnosed, What medications are taken?_____

Will medication be needed in school? __Yes __No

___Seizures What type?_____ Date of last seizure_____

Medication taken?_____

___Emotional Concerns _____

List any other recurrent medical problem or illness you would like the school to be aware of

_____

Physician_____ Phone_____

Dentist _____ Phone_____

Hospital_____

Your signature gives permission for school staff to take precautions and procedures to protect your child in the classroom and to foster academic success. Your signature is an informed consent to share this health history information with school staff on a need-to-know basis for emergency plans. In the event that reasonable attempt to contact me/us are unsuccessful, I/we give consent to any treatment deemed necessary by the physician or dentist named above or by another licensed physician or dentist, and for the transfer of the student to the hospital named above or to any hospital reasonably accessible.

Parent Signature _____ Date _____

Parent Signature _____ Date _____