ST. JOSEPH'S SCHOOL 2022-2023 PRE-KINDERGARTEN REGISTRATION FORM

Staff use only: Library Book fee $10.00____Paid

Registration Date: IN_____ and OUT _____

Families **new** to the school are required to pay a deposit of the first month's fee.

Tues & Thurs (4 yrs. and up) ▮▮ (2 ½ yrs. and up) Wed/Fri **OR** Wed **OR** Fri: 9:00 am - 1:00 pm
(circle one) $175 for 2 days a week / $88 for single/additional days Drop off at 8:45

Child's Name:_____ DOB: _____
First Last yyyy / mm / dd

FAMILY INFORMATION

Child lives with (please circle correct one) Mother Father Both Shared

Mother's Name: _____ email:_____

Place of Work: _____ (work #)_____

Mother's Phone #s: (home)_____ (cell)_____

Mailing Address: _____
Box Town Postal Code

Physical Address: _____

Father's Name: _____ email:_____

Place of Work: _____ (work #)_____

Father's Phone #s: (home) _____ (cell)_____

Mailing Address: _____
Box Town Postal Code

Physical Address: _____

Catholic: Y N (Are you registered with the Parish?) Y N

MEDICAL INFORMATION

Family Doctor:_____ Phone:_____

CARE CARD #:_____ Gender: M F

Medical Disabilities:_____ Known allergies: _____

Are there issues that may cause your child to have difficulties in Pre-K? Y N

If yes, what would those be? _____

EMERGENCY CONTACTS

1. Name: _____ Relationship: _____
   home phone: _____ work: _____ cell: _____
2. Name: _____ Relationship: _____
   home phone: _____ work: _____ cell: _____

CHILD RELEASE AUTHORIZATION

Consent is needed for another adult, other than a parent, to remove a child from the facility.

1. Name: _____ Relationship: _____
   home phone: _____ work: _____ cell: _____

2. Name: _____ Relationship: _____
   home phone: _____ work: _____ cell: _____

Signature of parent or guardian: _____

Please list siblings: _____

_____

_____

All children, as a condition of registration, require consent to call emergency medical services in the case of accident or illness where the parent or guardian cannot immediately be reached.

Signature of parent or guardian: _____

If there is a custody agreement, please give any details you wish us to be aware of:

_____

IMMUNIZATION RECORDS

Please indicate which immunizations your child has received.

AGE	VACCINE	✓
2 months	DaPT / IPV / HIB Hepatitis B Pneumococcal	
4 months	DaPT / IPV / HIB Hepatitis B Pneumococcal	
6 months	DaPT / IPV / HIB Hepatitis B Pneumococcal	
on or after 1st birthday	MMR Meningococcal C-C Chicken Pox	
18 months	DaPT / IPV / HIB Pneumococcal MMR	

DaPT: Diptheria Pertussis Tetanus
IPV: Inactivated Polio Vaccine
HIB: Haemophilus Infuenzai Type B Hib
MMR: Measles Mumps Rubella
Prevnar: Pneumococcal C

I declare the above information to be accurate and will inform staff of changes.

Signature: _____