

ST JOSEPH'S SCHOOL 2022-2023 PRESCHOOL REGISTRATION

Staff use only: Library Book fee \$10.00 ____ Registration Date: IN ____ and OUT ____

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

Session choice (circle one): Mon/Wed **OR** Tues/Thurs **OR** Mon-Thurs (all sessions are 12.30-3pm)

Fees: \$175/month for 2 days a week & 350 / month for 4 days a week

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

CHILD INFORMATION

Family Doctor: _____ Phone: _____

Personal health number (formerly Care Card #): _____ Gender: M F

Special/medical disabilities: _____ Known allergies: _____

Are there reasons your child may have difficulties or require extra support in preschool? Y N

If yes, please explain: _____

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 1 st birthday	MMR Meningococcal C-C Chicken Pox	
18 months	DaPT / IPV / HIB Pneumococcal MMR	

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

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

Signature: _____