



Transitional Kindergarten and Kindergarten

Child's Full Name:

Child's Birthday:

Child's Address

Parent 1: Name and Address:

Please List any services your child has received:

Parent 1:

Contact Phone: _____

I agree to text messages: _____

Contact Email: _____

Languages Spoken at Home:

Parent 2: Name and Address:

Sibling Name & Ages:

Parent 2:

Contact Phone: _____

I agree to text messages: _____

Contact Email: _____

List the full names & contact number of anyone who will pick up your child:

Child lives with:

Child's Dr & Number:

Please tell us the average Drop Off Time _____ and Pick Up Time _____

What is the desired Enrollment Start Date: _____

Parent signature / Date _____ Parent signature/ Date _____

OFFICE USE ONLY:

Date Registration Fee Received _____ Date Birth Certificate Received _____

Date Shot Record Received _____ Date Physicians Report Received _____

Child's name: _____ DOB: ____ / ____ / ____
First and last Month Day Year

Does your child have any:

1)Preschool or childcare experience? NO _____ YES _____ Where? _____
Previous kindergarten experience? NO _____ YES _____ Where? _____

(if you answer YES please provide most recent evaluation from former school or childcare)

2)Delays or concerns with speech/hearing, physical, emotional or social development?
NO _____ YES _____ Please list: _____

3)Food Allergies:

NO _____ YES _____ Please list: _____
List any signs or. Symptoms of a reaction: _____

4)Other Allergies:

NO _____ YES _____ Please list: _____
List any signs or. Symptoms of a reaction: _____

5)Medical conditions?(example: Asthma, Diabetes, Chronic Illness, Etc.)

NO _____ YES _____ Please list: _____

6)Does your child take any prescription medications?

NO _____ YES _____ Please list: _____

Does your child need to take this medication at school? NO _____ YES _____

7)Do both parents live in the household?

NO _____ YES _____

If no, we will need to be aware of any custody arrangements. Legal documentation is required for any pick-up restrictions.

8)Does your child have specific behaviors we should be aware of? (For example: separation anxiety, selective eater, other fears)

NO _____ YES _____ Please list: _____

9)How did you hear about our school:

____ Neighbor, friend or relative ____ Picked up flyer (where) _____

____ Website ____ Advertisement ____ Other public location(Where) _____

Parent Signature: _____ Date: _____

Best contact number: _____