

SUNSHINE PRESCHOOL at BREIEL CHURCH

For office use only

Registration for: _____ Class Days _____ Room _____
Date: _____ School Year: 2011/2012 Age: _____ Met _____
Registration Fee \$ _____ paid by Cash Check Receipt No. _____ Date: _____
Medical (JFS 01305) Returned (date): _____ Date Expires: _____
ODJFS 01234 : _____ Survey/History: _____ ODJFS 01217 : _____



Complete information below and return with registration fee (you must meet with administrator):

Name of Child: _____ Sex _____

Name to be used in school _____ Birthdate _____ Age _____

Home Address _____ Phone () _____

_____ e-mail _____

Mother's Name _____ Occupation _____

Address (if different) _____ Work Phone () _____

_____ Cell Phone () _____

Father's Name _____ Occupation _____

Address (if different) _____ Work Phone () _____

_____ Cell Phone () _____

Additional Household Members: _____ *Please indicate phone number student is to learn

Brothers' Names _____ Ages _____

Sisters' Names _____ Ages _____

Others _____

Pets _____

Previous Group Experiences _____

Is child accustomed to playing with other children? _____

Child's favorite activities or special interests _____

Is child right or left handed? _____

List any contagious diseases your child has had _____

Hours of sleep at night _____ Does child require an afternoon nap? _____

Types of discipline commonly used at home: _____

We will ask you to fill out a questionnaire about your child's development within 60 days of their first day as part of our Step Up To Quality program, in our effort to provide the best learning experience for your child.

Please share some of your child's strengths _____

Please share some of your child's weaknesses _____

Are there any special facts about your child's health or personality that would be helpful to the teacher?

Any special fears? _____

Any toileting problems? _____

List any allergies and special precautions or treatment indicated for these allergies: (*see note below)

List any medications currently being administered to your child: (*see note below)

List any chronic physical problems and any history of hospitalizations: (*see note below)

CHILD'S PHYSICIAN _____

ADDRESS _____

Street

city

Zip Code

PHONE () _____

PERSONS ALLOWED TO PICK UP CHILD, OTHER THAN PARENTS:

Name: _____ Name: _____

Phone () _____ Phone () _____

Relationship to Child _____ Relationship to Child _____

Name: _____ Name: _____

Phone () _____ Phone () _____

Relationship to Child _____ Relationship to Child _____

Any special instructions on who will pick up your child _____

Parent's Signature _____ Date _____

Registration form (gold), Survey/History (blue) and Enrollment/Health Information form (JFS 01234) **MUST BE ON FILE BEFORE CHILD'S FIRST CLASS.** Medical (JFS 01305) signed by physician, due 30 days from enrollment, valid for 1 year from the date of the examination. *May require additional JFS forms.