

St. Mary Pre-School Registration Form

Last Name _____ First _____ Middle _____

Name your child goes by _____ Birthdate _____

Address _____ City/State _____ Zip _____

Phone _____ Place of Birth (City/State) _____

Program Entering (Age by August 1st): 3/4 year-old AM 3/4 year-old PM
 4/5 year-old AM 4/5 year-old PM

Father, Step-Father, Male Guardian (circle one):

Name _____ Place of Birth (City/State) _____

Married Separated Divorced Single Parent Deceased

Religion _____ Occupation _____

Home Phone _____ Work Phone _____

Mother, Step-Mother, Female Guardian (circle one):

Name _____ Place of Birth (City/State) _____

Married Separated Divorced Single Parent Deceased

Religion _____ Occupation _____

Home Phone _____ Work Phone _____

Child lives with _____

If other than custodial male/female above, please fill in below:

Guardian _____ Phone _____

Address _____ City/State _____ Zip _____

Child's Baptism:

Parish Church _____ City/State _____ Date _____

Family is presently registered in _____ parish.

Non-Refundable Supply Fee (\$40.00) due at time of registration. Check Number/Cash _____ .

St. Mary Pre-School Health Form

Name _____ Male Female

Address _____ City/State _____ Zip _____

Phone _____ Birthdate _____

Father _____ Employer _____

Mother _____ Employer _____

Physician _____ Phone _____

Hospital Preference _____

Health History (Check for Yes)

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Measles/Rubella |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Aid/s | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Vision | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Seizures | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Low Blood Sugar | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Handicap
Specify: _____ | | |
| <input type="checkbox"/> Operations
Specify: _____ | | |
| <input type="checkbox"/> Medications:
Name/Frequency: _____ | | |

Other health information you want us to know: _____

Immunizations (list dates)

DPT _____

OPV _____

TB _____
MMR _____
HIB _____
