

ST. JOHN'S UNITED CHURCH OF CHRIST

PRESCHOOL REGISTRATION FORM

Date: _____

Class Enrolled: _____

| | | |
|----------------------|----------|------|
| Child's Name: | | |
| Birth date: | Sex: M F | |
| Street Address: | | |
| City: | State: | Zip: |
| Home Telephone: | | |

Brothers/Sisters

| | | |
|-------|------|-------------|
| Name: | Age: | Birth date: |
| | | |
| | | |
| | | |

| |
|--|
| Has a sibling attended St. John's Preschool? |
| Church affiliation: |

| | |
|--|-------------|
| Mother's Name: | Age: |
| Occupation: | Work Phone: |
| Mobile Phone: | |
| Father's Name: | Age: |
| Occupation: | Work Phone: |
| Mobile Phone: | |
| Marital Status of Parents: | |
| Parent – Special skills, hobbies, etc. | |
| | |

| Persons Authorized to Pick Up Your Child: | Relationship | Phone |
|---|--------------|-------|
| | | |
| | | |
| | | |

| Emergency Notification | | |
|------------------------|--------------|-------|
| Name | Relationship | Phone |
| | | |
| | | |

| Medical | |
|--------------------------------|--------|
| Child's Physician: | |
| Physician's Address: | Phone: |
| Emergency Hospital Preference: | |

Parent's Signature: _____

| |
|---|
| Does child have special fears? |
| Vision or hearing problems? |
| Should we be aware of any health problems? Explain: |

| |
|--|
| Foods or drinks your child should not have: |
| What does your child usually eat for breakfast? |
| Do you have concerns about any aspect of your child's development? |

| | | |
|---------------------------|-----------------------------|--------|
| Age at which your child: | | |
| Crawled on hand and knees | Sat alone | Walked |
| Named simple things | Spoke in complete sentences | |
| Slept through the night | Toilet trained | |

| |
|--|
| Do you feel your child's speech is clear? |
| Can strangers understand when your child's speaks? |
| Is a language other than English used in the home? |
| If so, please describe: |

| | | |
|--------------------------------------|---------------|-----------|
| List illnesses your child has had: | | |
| Does your child have frequent colds? | Sore throats? | Earaches? |
| Stomach aches? | Fever? | |

| | |
|--|----------|
| Has your child had any serious accidents or operations? | |
| If yes, please describe: | |
| Does your child have any allergies? | |
| If yes, please describe: | |
| Does your child take medication regularly? | |
| When was your child last seen by a doctor? | Dentist? |
| Should the staff be aware of any special medical, physical, or emotional needs for your child? | |
| | |
| | |
| How much television does your child watch each day? | |

What are your child's favorite activities?

What does your child enjoy doing with mother?

What does your child enjoy doing with father?

Does your child play well alone? _____

Are there neighborhood playmates?
If yes, with what age children does your child usually play?

Does your child accept correction easily?
What method of behavior control is used in your home?

Please circle the items that describe your child:

| | | | | |
|--------------|---------------|-----------|-------------|--------|
| Happy | Aggressive | Friendly | Moody | Clumsy |
| Dependent | Stubborn | Impulsive | Fearful | Quiet |
| Good-natured | Even-tempered | Attentive | Sympathetic | Shy |
| Sleepy | Other: | | | |

Has your child learned to:

| | |
|--|---------------------------|
| Say nursery rhymes? | Sing songs? |
| State his or her age and sex? | Dress self independently? |
| Recognize and name common objects? | Follow simple directions? |
| Count? _____ | How far? _____ |
| Name basic colors? | Hop on one foot? |
| Balance on one foot? | Ride a tricycle? |
| Write name? | Draw a person? |
| Other (note significant accomplishments) | |

Does your child have significant group play experience?
Has your child been cared for by someone besides the family?
If yes, please describe:

Has your child attended preschool or daycare previously?
If yes, please describe experience:

What do you hope will be included in your child's preschool experience?

For staff reference: Check those items on file:
Immunization Record: _____ Physical Examination _____ Birth Certificate _____