ST. SAVIOUR'S CHRISTIAN PRESCHOOL

REGISTRATION FORM

Name of Child: ____
Surname Given Name Middle Name

Name child responds to: ____ Sex: M ________ F ________

Child's starting date: ________________________________ Birth date: ______________________________
Year Month Date Year Month Date

Address: ____

Postal Code: _________________________________ Phone: __________________________________

Child's First Language: __________________________ Child's Second Language: ___________________

Parent(s) with whom child lives: ____

Parent / Guardian: (Authorized to pick up child)

Name: ____

Address: ____

Place of work: ____

Phone: (home) _______________________ (work) ____________________ (cell/pager) __________________

Name: ____

Address: ____

Place of work: ____

Phone: (home) _______________________ (work) ____________________ (cell/pager) __________________

Alternative Person(s) to Call in Case of Emergency: (other than parents)

Name: _______________________________ Address: ____
Relationship:______________________________ Phone: _______________________ Speaks English? ________
Name: _______________________________ Address: ____
Relationship:______________________________ Phone: _______________________ Speaks English? ________

Person(s) Authorized to Pick Up Child:

Name: ________________________________ Relationship: ___________________ Phone: _______________
Name: ________________________________ Relationship: ___________________ Phone: _______________
Name: ________________________________ Relationship: ___________________ Phone: _______________

If there is a custody agreement, please give any details you wish us to be aware of:
____
____

Social Information:

Names and birth dates of other children living at home:
____
____

Has child previously attended day care / preschool? Yes _____________ No _____________
Words child uses for toileting: ____

Health Information:

Does your child have: Please check Yes or No
Diagnosed medical concern or a life threatening allergy? Yes ____________ No ____________
If Yes, is medication prescribed for this condition? Yes ____________ No ____________
Name of Medication: ________________________________ When Given: ____________________________

Have you completed a "Permission to Administer Emergency Medication" form?
Yes ____________ No ____________

Does your child require a special diet related to health concerns? Yes ____________ No ____________
If yes, please describe: ____
____

Does your child have: Please check Yes or No
Speech / language concerns? Yes ____________ No ____________
Have difficulty hearing? Yes ____________ No ____________
Difficulty with vision? Yes ____________ No ____________
If yes, please describe the concern: ____
____

Is your child receiving services either privately or from the Richmond Health Department?
Yes ____________ No ____________
If yes, please describe: ____
____

Other health concerns you with to share with the staff: ______________________________________
____

Emergency Heath Contact Information:

Doctor: ____________________ Phone: ________________ Address: ______________________________
Dentist: ____________________ Phone: ________________ Address: ______________________________
Care Card Number: _________________________________

Immunization:

Parent: Immunization records are on file with the Richmond Health Department
Yes ____________ No ____________

Parent: Completed Richmond Health Department "Immunization Information for Child Care Facilities" (blue form) given to caregiver Yes ____________ No ____________

Caregiver: "Immunization Information for Child Care Facilities" (blue form) sent to or given to Community Health Nurse or Licensing Officer Yes ____________ No ____________

Additional Comments: ____
____
____

____________________________	____________________________	____________________________
Signature of Parent / Guardian	**Name (Print)**	**Date**