St. Aloysius Preschool

122 Mt. Mercy Drive-PO Box 190-Pewee Valley, KY 40056
(502) 241-8516-fax (502) 243-2241

3's Class

____ Tues/Wed/Thurs

____ Mon-Fri

____ Full Day ____ ½ Day (am)

4'sClass

____ Mon-Fri

____ Full Day

____ ½ Day

Child's Name_____ Gender _____

Birth Date _____

Mother's Name_____ Phone# _____

Home Address_____

Email_____

Employer _____ Phone# _____

Father's Name_____ Phone# _____

Home Address_____

Email_____

Employer _____ Phone# _____

Person/s with whom the child lives:

_____

Child's Physician: _____Phone #:_____

Preferred Hospital: _____

Insurance Carrier:_____

Member Name:_____

Policy number and Group Number:_____

Parent/Guardian consent: I hereby give permission to St. Aloysius Preschool to secure and authorize emergency medical care and/or treatment as the above-named child might require while under supervision of preschool staff. I further authorize St. Aloysius staff to administer emergency care/treatment as required until further medical assistance is available. I agree to pay costs contingent on any emergency medical care/treatment for said child as secured or authorized under this consent.

Individuals to contact in the case of an emergency:

_____ Phone #: _____

_____ Phone #: _____

_____ Phone #: _____

_____ Phone #: _____

Does your child have any food allergies? No Yes_____

Does your child have any dietary restrictions? No Yes _____

Does your child have any special needs? No Yes _____

Does your child receive any special services? No Yes _____

Is your child Catholic? No Yes

What is your child's ethnicity? _____

My child has permission to be released to the following individuals or transportation services in addition to the emergency contact persons listed above. (Please notify all individuals that they may be asked to show proof of identity.)

1)_____ Phone #_____

2)_____ Phone #_____

3)_____ Phone #_____

4)_____ Phone #_____

What language does your child speak most often: _____

Can your child manage these things independently? ***3-year-olds must be potty trained-no pullups and able to use the bathroom self sufficiently daily***

____ Wipe after toilet use ____ Blow/wipe nose ____ Wash hands properly

____ Eat Independently ____ Manage clothes in the bathroom

Past Preschool or Childcare Experience No Yes (if so where) _____

Please Sign Below:

My/Our signature below verifies that the information set forth in the application is true and correct, including the medical authorization. I/We understand that any inaccurate or missing information may be the reason for rejection of the application and dismissal of my/our child from school.

Father/Guardian _____ Date _____

Mother/Guardian _____ Date _____

Registration Fee: $150 Paid _____ Date _____

Program Fee: $175 Paid _____ Date _____

Copy of Birth Certificate (not the one from the hospital)