Learning For His Glory Preschool
Student Registration

Child's Name: _______________________________________ Date:___________________

Date of Birth: ____/____/____ Age:________ ____ Male ____ Female

Address: ____

__________________ ___________________ ____________________

City State Zip Code

Child lives with(check all that apply): ____ Mother & Father ___Mother ___Father ___Other

Parent/Guardian (Mother) Name: _____________________ Phone:__________________

Place of Employment: _______________________________ Phone:__________________

Email:____

Parent/Guardian (Father) Name: _____________________ Phone:__________________

Place of Employment: _______________________________ Phone:__________________

Email:____

Has your child ever attended preschool? __ yes __no If yes, where? _________________

Church affiliation:____

Emergency Contact/ My child may be picked up by:

Name: _____________________ Relationship:_______________ Phone:______________

Name: _____________________ Relationship:_______________ Phone:______________

Name: _____________________ Relationship:_______________ Phone:______________

Name: _____________________ Relationship:_______________ Phone:______________

Photograph Permission: I give Mt. Vernon preschool permission to photograph my child during school and/or daycare activities. ________ I accept _________ I decline

Medical Release Form (in the event of a medical emergency involving my child)

Print Child's Name:____

I understand that Mt. Vernon Preschool will make every effort to contact me in the event of a medical emergency involving my child. If the school cannot reach me, I give permission for the school to seek medical attention for my child. Any medical fees incurred will be my responsibility. I agree to hold harmless Mt. Vernon Preschool for their actions on my behalf.

Parent: ____ Date:____________________

Doctor: ____ Phone:___________________

Is your child allergic to foods, medicine, or insect stings/bites? _________________________

**If yes, provide a list of all allergies

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Child Medical Report

Child's Name: ___________________________________ Date of Birth:____/____/____

Parent/Guardian Name: ____________________________ Phone: ________________

Address: ____

________________ ________________ ____________________
City State Zip Code

In addition to a medical report or medical screening, a Certificate of Immunization (ADPH-F-IMM-50) is required for each child two months to five years of age and for five-year-olds who are not enrolled in public or private school.

History of Allergies:

____

____

____

____

I examined this child on (date) ___________________. I find him/her to be in good physical condition and free of contagious and infectious diseases except as noted below.

____

____

____

____

____
Signature of Physician, Physician's Assistant, Certified Nurse Practitioner

____
Date