

**ENROLLMENT RECORD**

Date: \_\_\_\_\_

\*\*Please print all information\*\*

Child's Name \_\_\_\_\_ Name to be called at school: \_\_\_\_\_

Sex: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age on Sept. 1<sup>st</sup>: Years \_\_\_\_\_ Months \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ **BEST NUMBER TO REACH US:** (\_\_\_\_\_) \_\_\_\_\_  
(for directory/School Rush)

E-mail address (for directory/School Rush): \_\_\_\_\_ (mother)

E-mail address (for directory/School Rush): \_\_\_\_\_ (father)

**NAME AND RELATIONSHIP OF RESPONSIBLE ADULT(S) WITH WHOM THE CHILD RESIDES:**

Name \_\_\_\_\_ Relationship to child: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Company Name: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Company Name: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**EMERGENCY INFORMATION:**

Names, addresses, and telephone numbers other than those above to contact, within the immediate area, if parent or guardian cannot be contacted in case of emergency. **THREE NAMES AND COMPLETE INFORMATION ARE REQUIRED BY DCFS.** These individuals are also authorized to pick up my child:

1 \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Name relationship to child Street Address/City/Zip Phone

2 \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Name relationship to child Street Address/City/Zip Phone

3 \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Name relationship to child Street Address/City/Zip Phone

Child's Doctor: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Name Address/City Phone

Child's Dentist: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Name Address/City Phone

1. Does your child have any allergies? (food, medications, insect bites, etc.) \_\_\_\_\_

2. Does your child require a special diet? (if yes, please explain) \_\_\_\_\_

3. List any medications your child takes regularly: \_\_\_\_\_

4. Does your child have any physical handicaps? (explain) \_\_\_\_\_

5. Does your child wear: glasses \_\_\_\_\_ orthopedic appliances: \_\_\_\_\_ Special clothing or shoes: \_\_\_\_\_

6. Which hand preference has your child shown? Right \_\_\_\_\_ Left \_\_\_\_\_ No preference \_\_\_\_\_

7. Has your child attended any other preschool programs? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, where and how long? \_\_\_\_\_

8. Which kindergarten will your child be attending? \_\_\_\_\_

9. What do you want your child to get most from preschool? \_\_\_\_\_

10. Are there any circumstances or changes in your family or home that has or may have an affect on your child?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

11. Is there any other information about your child that you believe we should be aware of?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

12. List other children in the household:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

13. Optional:

Father's occupation: \_\_\_\_\_

Special interests/hobbies: \_\_\_\_\_

Mother's occupation: \_\_\_\_\_

Special interests/hobbies: \_\_\_\_\_

# CHILD PICKUP

Child's Name : \_\_\_\_\_ Class(es): \_\_\_\_\_  
\_\_\_\_\_

**I/WE AUTHORIZE THE INDIVIDUALS LISTED ON THE EMERGENCY INFORMATION SECTION OF THIS REGISTRATION FORM AS WELL AS THE FOLLOWING INDIVIDUALS TO PICK UP MY CHILD:**

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**OR**

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**OR**

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**OR**

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**SIGNATURE OF BOTH PARENTS/GUARDIANS IS REQUIRED. If one parent/guardian is unavailable for signature, please include that name on the authorization above.**

\_\_\_\_\_  
Signature of Parent/Guardian Date

\_\_\_\_\_  
Signature of Parent/Guardian Date

**To the best of my knowledge, all the information contained in this application is true and correct and I understand that it my responsibility to notify Salem Methodist Preschool if any of the information on this application changes.**

\_\_\_\_\_  
Signature of Parent/Guardian Date

PLEASE TURN OVER FOR PAGE 4

# PERMISSION FORM

1. I hereby grant permission for my child to use all the play equipment and participate in all of the activities of the school.
2. I hereby grant permission for my child to leave the school premises under the supervision of a staff member for neighborhood walks.
3. I hereby grant permission for my child to accompany his/her class and staff persons on field trips planned and authorized by the center, when reasonable care is given to assure the child's safety.
4. I hereby grant permission for the staff of Salem Methodist Preschool to take whatever steps may be necessary to obtain emergency medical and dental care if warranted. These steps may include, but are not limited to:
  - a. Contact local paramedics
  - b. If they deem treatment necessary, transport the child to the nearest hospital
  - c. Attempt to contact a parent or guardian
  - d. Attempt to contact you through any of the person's listed on your child's emergency card;
  - e. Attempt to contact the child's physician or certified Christian practitioner;
  - f. If we cannot contact the child's physician or certified Christian practitioner; we will do the following:
    1. call another physician
    2. have the child taken to an emergency center in the company of a staff member, or
    3. call an ambulance
5. Any expenses incurred under item number 4, will be borne by the child's family.
6. The school will NOT assume responsibility for a child who has NOT been signed in when he/she arrives for the day.
7. The school will NOT assume responsibility for anything that may occur as a result of false information given at the time of enrollment.
8. Injury sustained at school must be reported with 24 hours to the Director or Acting Director.
9. I am aware that the children will say table grace before snack time and Stay 'N Play lunch, and will be taught Christian concepts appropriate for preschool children at the religious holidays.
10. I give permission for my child's name, parent/guardian name, address, and phone number to be printed in the Salem Methodist Preschool directory.
11. I give permission for our email address to be printed in the Student Directory as part of my child's class roster.

**I hereby agree with all of the above and grant permission for the staff to administer emergency first aid.**

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**

12. I hereby grant permission for my child's photo/image to be included in the preschool newsletter, Facebook page, website or other social media outlets and publications. There will **NOT** be any personally identifiable information posted

**I grant/NOT grant permission for: (Please check Yes or No for each of the following items)**

\_\_\_\_\_ Yes    \_\_\_\_\_ No    **School Rush (in-house phone app – parents and staff only)**

\_\_\_\_\_ Yes    \_\_\_\_\_ No    **Preschool Website**

\_\_\_\_\_ Yes    \_\_\_\_\_ No    **Preschool Newsletter**

\_\_\_\_\_ Yes    \_\_\_\_\_ No    **Preschool Facebook page or other social media outlets**

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**

**Salem Methodist Preschool  
Special Needs Assessment**

Child: \_\_\_\_\_ Class: \_\_\_\_\_

This survey is confidential. To best serve the needs of your child, we ask that you complete this survey. If your child needs special assistance with medical conditions, we need to know. It is our belief that early intervention, if needed, with speech, vision, hearing, occupational therapy, physical therapy, etc. ensures future success in school.

1. Does your child have allergies? To what?

What should we know about your child and his/her symptoms/reactions?

How is your child treated for these allergies?

Note: An allergy alert form will be sent home prior to the start of the school year for you to complete for the office.

2. Does your child have special medical needs?

3. Does your child take medication on a regular basis? Please explain.

4. Has your child participated in early childhood screening by your school district? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, which district? \_\_\_\_\_

Does your child require special services? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain.

5. Is your child receiving private services? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, what for and for what amount of time?

6. Is your child currently attending the Early Learning Center in Barrington District 220 (or other district)? \_\_\_\_\_ Yes \_\_\_\_\_ No

Will they continue to attend the ELC (or other program) while coming to Salem Methodist Preschool?

In which are is your child receiving services?

\_\_\_\_\_ Speech

\_\_\_\_\_ Hearing

\_\_\_\_\_ Occupational Therapy

\_\_\_\_\_ Vision

\_\_\_\_\_ Physical Therapy

\_\_\_\_\_ Other – Please explain:

Comments: