

Collins-Maxwell Community School

2015-2016 Preschool Registration Form

Student Information

Legal Name: _____
 First Middle Last Birth Date Gender

Name Student goes by if different from above: _____

<u>Ethnicity</u>
<input type="checkbox"/> Am. Indian or Alaska Native
<input type="checkbox"/> Asian
<input type="checkbox"/> Black or African American
<input type="checkbox"/> Native Pacific Islander
<input type="checkbox"/> White (caucasian)
Hispanic yes <input type="checkbox"/> no <input type="checkbox"/>

Parent/Guardian RESIDING with Student

Name(s) _____
Address _____
City, State, Zip _____
Phone Numbers
Home: _____
Mom: _____ (cell)
 _____ (work)
Dad: _____ (cell)
 _____ (work)
e-mail: _____

Parent NOT RESIDING with Student if Applicable

Name _____
Address _____
Phone (home) _____
(work/cell) _____

Permission to attend daytime field trips
<input type="checkbox"/> YES <input type="checkbox"/> NO

Day Care Provider Name _____ Phone Number _____

Please list 2 neighbors or relatives who will assume temporary care of your child if you cannot be reached:

Name _____ Phone _____
Name _____ Phone _____

YOUNGER SIBLINGS
Name _____ Birthdate _____
Name _____ Birthdate _____

PLEASE FILL OUT HEALTH INFORMATION ON BACK OF THIS FORM

Collins-Maxwell School Health Information

This information will give the school nurse a background to your child's health and concerns he/she may have. This information will be considered confidential and will be kept with your child's health record.

Name: _____ Date of Birth: _____ Gender: M/F

Parent/Guardian Name: _____ Grade: _____ Teacher/Advisor: _____

Emergency Contacts (if parents are not able to be reached)—If your child needs to be taken home due to illness or injury and you cannot be reached, we will call the emergency contact person listed on the first page.

- Have these people agreed to assume this responsibility in case of emergency and agreed to take your child home if he/she becomes ill at school? **Yes/No**
- If we are unable to contact you or the above people, will you grant us permission to get medical treatment if we feel it is necessary? **Yes/No**

Family Doctor: _____ Phone: _____ Last physical exam: _____

Family Dentist: _____ Phone: _____ Last dental exam: _____

Eye Doctor: _____ Phone: _____ Last eye exam date: _____

Lenses/contacts: Yes/No Full-time/Reading only

Has he or she had chicken pox: yes/no Date they had them: _____

Surgery/Serious illness/Injury/Hospitalizations:

List any special dietary needs/restrictions (allergy to milk, diabetic, increase fiber, low cholesterol, etc):

ANY SPECIAL DIETARY NEEDS *REQUIRE* A NOTE FROM YOUR PHYSICIAN!

Any Known Drug Allergies: Yes/No. If yes, please list: _____

Any Food Allergies: Yes/No. If yes, please list: _____

Any other allergies, please list: _____

Health Condition(s) – check/circle any of the following that your child has had, or currently is a concern:

____ Toileting issues ____ Frequent nosebleeds ____ Frequent colds ____ Seizures ____ Diabetes
____ Asthma/wheezing ____ Stomach aches ____ Heart Problems ____ Special Procedures
____ Pneumonia/Bronchitis ____ Tube(s) in ear(s)--right/left/both ____ ADHD/ADD/ODD/OCD
____ Frequent headaches ____ Migraines ____ Frequent sore throat, tonsillitis
____ Eye problems: poor vision, crossed eyes, muscle imbalance ____ Other: explain below

Please explain any marked answers: _____

Medications: Is your child taking ANY medication (including inhalers, over-the-counter meds, etc.)? **Yes/No (Please attach a separate sheet if there are more medications)**

If **yes:** Medication: _____

Dose: _____

Times: _____

Purpose: _____

Doctor who prescribes the medication: _____

Please remember that ALL medications sent to school must be in any original Pharmacy labeled container and accompanied by a written permission to give them to your child at school!

At School Permission for the following: I give permission for my child to be given (**PLEASE CIRCLE**)

*Ibuprofen *Acetaminophen (Tylenol) *Antacid (Tums) *Cough Drops *Topical lotions to be applied if needed

Health information may be shared with pertinent school personnel Yes _____ No _____

Parent Signature: _____ Date: _____