



**ST. JOSEPH'S CATHOLIC  
SCHOOL  
PRESCHOOL  
REGISTRATION FORM  
Combined 3 & 4 Year Old Program**

FOR OFFICE USE ONLY

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

\$25.00 Application Fee Received

CHILD'S SURNAME: \_\_\_\_\_ GIVEN NAMES: \_\_\_\_\_

NAME CHILD RESPONDS TO: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Birth (Year/Month/Day): \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDRESS \_\_\_\_\_ POSTAL CODE \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

DESIRED DATE OF ENROLMENT: \_\_\_\_\_

**PARENTS/GUARDIANS**

Name \_\_\_\_\_

Name \_\_\_\_\_

Place of Work \_\_\_\_\_

Place of Work \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Hours of Work \_\_\_\_\_

Hours of Work \_\_\_\_\_

Email Address \_\_\_\_\_

Email Address \_\_\_\_\_

REGISTERING FOR:  8:40 - 11:00 AM  12:30 - 2:50 PM

1 day/week  2 days/week  3 days/week  4 days/week  5 days/week

CHILD'S FIRST LANGUAGE: \_\_\_\_\_

SECOND LANGUAGE: \_\_\_\_\_

What level of English does your child understand to follow directions?

None  Little  Average for Age

**Persons authorized to pick up my child from the Child Care Program: (please PRINT)**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

**Persons NOT permitted access to child: (please PRINT)**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

Court Order on File:  Yes  No

**Other children living at home:**

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

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Year Month Day

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

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Year Month Day

Has your child had experience away from home (for example, Day Care, Nursery, Sunday School, etc.)?

Yes

No

Where? \_\_\_\_\_ Dates of Attendance: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_

Where you aware of any particular problems? \_\_\_\_\_

\_\_\_\_\_

**EMERGENCY HEALTH INFORMATION**

Personal Health Number (Care Card): \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone #: \_\_\_\_\_

Medical Alert: \_\_\_\_\_

Dietary Concerns: \_\_\_\_\_

**EMERGENCY CONSENT**

It is the policy of this Center to notify a parent when a child is seriously ill or injured and is in need of medical attention. Occasionally we cannot contact parents and we need to get immediate help for your child.

When I cannot be contacted I hereby give my consent for my child

\_\_\_\_\_ to be taken to the nearest hospital.  
*Last Name* *First Name*

A staff member will accompany your child in the ambulance. I agree to meet the ambulance at the hospital.

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

\_\_\_\_\_  
Parent/Guardian (please print name)

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