ST. PATRICK SCHOOL

PRE-REGISTRATION FORM

Class Preference

____ 3 year old Clover Patch (MWF)

____3 year old Clover Patch (TTH)

____4 year old Junior Kindergarten (Classes split by age)

____5 year old Kindergarten (Classes split by age)

**Parents will still need to register in the fall. Pre-registration does not guarantee a spot. We will use returning families and age to be the determining factor.

Student Information

Student's Full Name: _______________Student's Birthdate: _____________

Address: _______________________City, State: ______________________

Gender: __________Bus Rider (must be 4 years old) ☐ Yes ☐ No

Contact Information

Student lives with ☐ Mother ☐ Father ☐ Both ☐ Other(please specify) ______

____

Parent/Guardian name:___________ Parent/Guardian name: _____________

Relationship to student: _________ Relationship to student: ____________

Employer: _____________________ Employer: _______________________

Work Phone: ___________________ Work Phone: _____________________

Home Phone: ___________________ Home Phone: _____________________

Cell Phone: ____________________ Cell Phone: _______________________

Email: ________________________ Email: ___________________________

Please list other children living in the same household with ages:

____

____

Other Contacts

(List someone other than yourself, who agrees to care for and provide transportation for your child if he/she becomes ill and you cannot be reached.)

Name: ________________ Relationship to student: ____________________

Work Phone: _____________ Cell Phone: ______________ Home Phone: ______________

Name: ________________ Relationship to student: ____________________

Work Phone: _____________ Cell Phone: ______________ Home Phone: ______________

Emergency Information (Please fill out thoroughly)

<table>
<tr><td>Student's Doctor's Name:</td><td>Hospital Choice:</td></tr>
<tr><td>Doctor's Telephone Number:

Doctor's Address:</td><td>Does the child have health insurance?
___Yes, Company_________________
ID # ____________________________
___No</td></tr>
<tr><td>Student's Dentist's Name:</td><td rowspan="2">Does the child have dental insurance?
__Yes, Company ________________
ID# ___________________________
____No</td></tr>
<tr><td>Dentist's Telephone Number:

Dentist's Address:</td></tr>
</table>

In the event of an emergency, the school is authorized to obtain EMERGENCY MEDICAL or DENTAL CARE even if the school is unable to immediately make contact with the parent/guardian.

☐ Yes ☐ No

Parent/Guardian Signature: ______________________________________

Medical Alert

Please list any medical conditions/circumstances such as asthma, diabetes, allergies, seizures, etc:

____

____

____

Please list any medications taken daily by student: _______________________________________

____

Any other information that you feel the school personnel should be aware of:

____

____

Printed name of person filling out form: ____

Signature of person filling out form: ____

Relationship to student: _________________________ Date: _______________________