



SMCE Preschool

4 Year Old Preschool Application Form

Please **PRINT** all information.

Please designate your first choice with a #1 and your second choice with a #2.

Pre 4 AM (3d)

Pre 4 All Day (3d)

Pre 4 AM (5d)

Pre 4 All Day (5d)

CHILD INFORMATION

Name: _____
Last _____ First _____ Middle _____ Male Female Date _____

Date of Birth: _____ / _____ / _____ Birth Certificate No. _____ Place of Birth: _____
Month Day Year City State Religion/Parish: _____

Address: _____
House No. _____ Street _____ Apt. No. _____ Lot No. _____ City _____ State _____ Zip _____
Home Phone # _____ Cell Phone # _____

Child lives with: Both Parents Mother Father Other Relationship: _____ Legal Custody with: _____
(Must provide court papers)

Public School District of Residence: _____ Did child attend another preschool? No Yes Name of School (if Yes): _____

What language(s) does the child speak? _____ What language is spoken in the home? _____

FAMILY INFORMATION

| | First/Last Name | Home Address | Home Phone # | Place of Employment | Work Address | Work Phone # |
|--------------------|-----------------|--------------|--------------|---------------------|--------------|--------------|
| Father | | | | | | |
| Mother | | | | | | |
| Step-Parent | | | | | | |
| Step-Parent | | | | | | |
| Other | | | | | | |

Other Children Living in Home:

| First/Last Name | Relationship to Applicant | Birth Date |
|-----------------|---------------------------|------------|
| | | |
| | | |
| | | |

Child's Physical Description at Time of Application

| | |
|------------|-------------|
| Eye Color: | Hair Color: |
| Height: | Weight: |

Over

HEALTH INFORMATION

Does child have health insurance coverage? No Yes

Name of Physician or Clinic: _____

Phone #: _____

Has child ever had surgery? No Yes

Type of operation: _____

Date: _____

Does child have allergies? No Yes

Type: _____

Allergy Medication: _____

Does child have allergies to any medication? No Yes Type: _____

List prescription medications child is currently taking: _____

Medical Conditions: Diabetes: No Yes Heart Problems: No Yes

Epilepsy: No Yes Asthma: No Yes

Other: _____

Records were copied on: _____
Date _____

Initials: _____

OTHER INFORMATION

In order to properly plan for an incoming student, the school needs to know if there is any educational, developmental, psychological, behavioral, social, or medical history that affects the student's learning.

Please check No or Yes if your child has received any of these services. If Yes, please briefly describe.

Early Intervention Program No Yes _____

Developmental History: No Yes _____

Medical History: No Yes _____

Physical Conditions: No Yes _____

Other: No Yes _____

Ethnicity: Black Asian Hawaiian/Pacific Islander Native American/Alaskan
 White Multiracial Hispanic Non-Hispanic

By placing my/our signature(s) below, I/we verify that all information is accurate and complete. I/We realize that failure to provide accurate information about my/our child may jeopardize enrollment at this school. I/We further verify that no information has been omitted.

Parent/Guardian Signature _____

Please Print Name _____

Email Address _____

Date _____

Parent/Guardian Signature _____

Please Print Name _____

Email Address _____

Date _____