

St. Catherine of Sweden Church
Preschool
P.O. Box 246
2554 Wildwood Road
Wildwood, PA 15091

Registration Form

Date of Enrollment: _____ Session: Morning/Afternoon/Either
3 year/4 year/Pre-K

Name of Child: _____ Birthdate: __/__/__ Sex: M__ F__

Full name of Mother: _____

Full name of Father: _____

Family Email Address _____

Mother's Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Place of work: _____ Hours: _____

Father's Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Place of work: _____ Hours: _____

Person(s) to contact incase of emergency/Authorized to pick up child:

1. Name: _____ 2. Name: _____

Relationship to child: _____ Relationship to child: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Other Person(s) Authorized to pick up child:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Names of other children in family:

Name: _____ Birthdate: __/__/__

Name: _____ Birthdate: __/__/__

Name: _____ Birthdate: __/__/__

Religion _____

Name of Parish or Church _____

School District _____

Signature of Parent or Guardian _____

- Please enclose your 50.00 non-refundable registration feel with the completed form.
- Have you had another child enrolled in St. Catherine's Pre-School? Yes / No

Child's Health History

Does child have any known health problems? Yes () No () (If yes attach documentation)

Check (√) any of the following illnesses the child has had:

- Asthma Earaches Mumps Whooping Cough Bronchitis
Eczema Pneumonia Polio Chicken Pox Frequent Colds
Croup Convulsions Measles Influenza Rheumatic Fever
Diphtheria Tonsillitis Tonsillitis Other: _____

Please list any injuries child has had: _____

Does your child have any known allergies? Yes () No () If yes, what are they and what are your child's reactions: _____

Does your child take any medication on a regular basis? Yes () No () If yes please list the name of the medication(s) and the medical condition for which it is taken:

Do you have any concerns about your child's development? Yes () No () If yes please comment: _____

Please comment on any other medical information/ or special need the child care provider should be aware of: _____

I authorize the child care provider/staff to obtain the following services for this child if necessary: Public Health Nurse, Physician and or Ambulance in the event of an emergency. (ambulance fees and/or health care costs are the responsibility of the parent/guardian)

(Date)

(Signature of parent/guardian)

(Signature of child care provider)

(signature of parent/guardian)