

Today's Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**LITTLE ANGEL PRESCHOOL ENROLLMENT FORM**  
**Summer Fun Program, June 1st, 2020 – August 28<sup>th</sup>, 2020**

Child's Name \_\_\_\_\_, \_\_\_\_\_ **Boy Girl**  
Last First—name you prefer your child to be called (circle one)

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Requested Schedule (Circle amount of days) 2, 3, 4, 5 days  
Month Day Year (Circle one) (Circle days)

Starting Date \_\_\_\_\_  
Half Days Full Days  
7:00 – 12:30 7:00 – 6:00 M, T, W, TH, F

Home Address \_\_\_\_\_ Apt. \_\_\_\_\_  
Street  
\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_ E-mail address \_\_\_\_\_

**Family Information:**

_____ Mother's or Guardian's Name	_____ Father's or Guardian's Name
_____ Place of Employment	_____ Place of Employment
_____ Street Address	_____ Street Address
_____ City, State, Zip	_____ City, State, Zip
_____ Work Telephone Number	_____ Work Telephone Number
_____ Cell Phone Number	_____ Cell Phone Number

Marital Status  Unmarried  Married  Separated  Divorced

Child lives with \_\_\_\_\_

**Emergency Contact Persons:**

1. _____ Name	_____ Relationship to Child	_____ Phone
2. _____ Name	_____ Relationship to Child	_____ Phone

In case of emergency, please take my child to the following local hospital.

\_\_\_\_\_ Hospital \_\_\_\_\_ Physician's Name \_\_\_\_\_ Phone

**Medical Information:** Please check any that applies to your child.

- |                            |                              |                      |
|----------------------------|------------------------------|----------------------|
| ___ 4 or more colds yearly | ___ Tonsillitis              | ___ Lyme disease     |
| ___ Chicken Pox            | ___ Strep Infections         | ___ Ear Infections   |
| ___ Pneumonia              | ___ Diabetes                 | ___ Asthma           |
| ___ Hearing Loss           | ___ Convulsive Disorders     | ___ Vision Problems  |
| ___ Drug Sensitive         | ___ Behavior Problems        | ___ Nose Bleeding    |
| ___ Fractures/Broken Bones | ___ Exposure to Tuberculosis | ___ Persistent Cough |
| ___ Other _____            |                              |                      |

**Toilet Habits** Is your child potty trained? (Circle) Yes/No How long? \_\_\_\_\_

**My child**

- \_\_\_ is able to express the need to use the toilet    \_\_\_ is able to use the toilet without assistance  
\_\_\_ is able to use the toilet only with assistance    \_\_\_ is able to use the toilet without prompting  
\_\_\_ must be prompted to use the toilet  
Soils clothing (please check one) \_\_\_ never \_\_\_ occasionally (1 or 2 times per month)  
\_\_\_ frequently (1or 2 times per week) \_\_\_ daily \_\_\_ always unless assisted with toilet

**Personal Information**

Any known allergies? \_\_\_\_\_  
Food restrictions? \_\_\_\_\_  
Any siblings? (Names & ages) \_\_\_\_\_  
Other preschools attended \_\_\_\_\_  
Special groups your child is a part of \_\_\_\_\_  
Does your family attend church? (Circle) Yes/No If yes, where: \_\_\_\_\_  
Name of Pastor \_\_\_\_\_ Name \_\_\_\_\_ Location \_\_\_\_\_

**I understand that if I need to withdraw my child for any reason, I must fill out a Withdrawal Form 2 weeks prior to the withdrawal and that failure to do so will make me financially responsible for those two weeks.**

\_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_ Date