Clover Patch Preschool/Daycare Student Information Sheet

Assessment/Health Form & Immunization Declaration

Today's Date:_____ Student's Date of Birth: _____

Student Last Name: _____ First Name: _____

Name child goes by if different from above: _____

Address _____ City _____ Zip _____

Student lives with: ☐ Both parents ☐ Mother ☐ Father ☐ Other

Parent: _____ Phone number _____

Parent: _____ Phone number _____

Email addresses preferred for correspondence: _____

Siblings: Names and birthdays _____

EMERGENCY CONTACT NAME(S)/NUMBER (S):

_____

_____

Student will be brought to school by: _____

List who can pick up your student: _____

List who can NOT pick up your student: _____

Early dismissal plan (weather, etc.) _____

I give permission to St. Patrick Catholic School for the following for my student:

- Seek emergency care if neither parents nor emergency contacts can be reached. ☐ Yes ☐ No
- Give non-prescription medication (Tylenol, etc.) ☐ Yes ☐ No
- Be photographed (yearbook/newspaper/school media): ☐ Yes ☐ No
- Be included in the school family directory: ☐ Yes ☐ No

Doctor Name: _____ Phone number: _____

Dentist Name: _____ Phone number: _____

Toilet habits (independent, frequency, or special concerns): _____

Resting habits (bedtime and naps): _____

Social experiences (does your child have opportunities to play with others): _____

_____

Method of discipline used at home: _____

Is your child excited for preschool? Any fears:

_____

Parental hopes for this preschool experience: _____

_____

Is this your child's first out of the home experience? _____

PHYSICAL ASSESSMENT - anything Clover Patch staff should be aware of or compensate by appropriate action?

Concerns of vision, hearing, or speech _____

Limitation of classroom activities _____

Any condition that may result in an emergency situation _____

Subject to any physical or mental condition that he/she should remain under periodic medical observation

_____

Significant illnesses and surgeries child has had (give age at time): _____

_____

Any special health-related needs of child (allergies, medications, injuries, etc.): _____

_____

Please share any information about your child or family you feel we should know (kept confidential) that would affect your child's experience at preschool.

_____

_____

_____

_____

FOR STUDENTS USING CIRCLE OF CARE (6:45-8:10 and/or 3:15-5:30)

My child will be using Circle of Care ($4/hour) ☐ In morning (6:45-8:10) ☐ After school (3:15-5:30)

☐ I/we have read the St. Patrick Clover Patch Preschool/Daycare / Circle of Care Handbook and understand the policies set forth. The handbook can be found on our website under the Parent Resources tab at the top of our home page. Two copies are available in the school office to review upon request.

☐ I/we give permission for my preschool student to ride the bus to Clover Patch in the morning.

My signature below certifies that immunization information concerning my child has been provided and is available in the school office.

_____ _____

Parent signature Date