

Circle Program: 3 4 (Mon-Wed.) 4 (Mon.-Thurs.)

Date Reg. Rec'd \_\_\_\_\_  
Check No. \_\_\_\_\_  
Check Amt. \_\_\_\_\_  
Date Activity Fee Rec'd \_\_\_\_\_  
Check No. \_\_\_\_\_  
Check Amt. \_\_\_\_\_

**SHEPHERD OF THE HILL CHRISTIAN PRESCHOOL  
REGISTRATION FORM**

**GENERAL INFORMATION:**

Child's Name: \_\_\_\_\_ Sex: M F

Birthdate: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Parents'/Guardians' Names: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(Street) (City) (Zip)

Home Telephone: \_\_\_\_\_ Current Church: \_\_\_\_\_  
(Circle: Home # or Cell #)

E-mail Address: \_\_\_\_\_

Mother's Work Hours: \_\_\_\_\_ Address: \_\_\_\_\_

Mother's Work Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_

Father's Work Hours: \_\_\_\_\_ Address: \_\_\_\_\_

Father's Work Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_

If I do not personally pick up my child from school, I have authorized the following people (including my spouse or non-custodial parent) to do so:

Name	Relationship to Child	Telephone

**EMERGENCY:**

If parents cannot be reached at the above listed telephone numbers, call (this person must live in close proximity to the Preschool):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

I give my permission for my child to be treated by a physician or emergency medical facility in the event I cannot be reached.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

**ALLERGIES:** Y N If yes, please specify: \_\_\_\_\_

**SPECIFIC:** I understand that this is a private, parochial school and religious experiences will be included in daily activities.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SOCIAL HISTORY:**

Child's Name: \_\_\_\_\_

How many brothers \_\_\_\_\_ or sisters \_\_\_\_\_ does your child have?

Name	Age	Name	Age
1. _____		5. _____	
2. _____		6. _____	
3. _____		7. _____	
4. _____		8. _____	

Parent(s), do you have a special occupation or hobby which may be shared with our children?

\_\_\_\_\_  
\_\_\_\_\_

Is this your child's first experience in an organized situation? List other experiences.

\_\_\_\_\_  
\_\_\_\_\_

Please answer the following to the best of your ability:

1. List physical capabilities which your child has, e.g., bounces ball well.

\_\_\_\_\_  
\_\_\_\_\_

2. List personality traits, e.g., shy, moody, temper tantrums, etc.

\_\_\_\_\_  
\_\_\_\_\_

3. Does your child have any special needs?

\_\_\_\_\_

4. Does your child have any strong likes? \_\_\_\_\_

Dislikes? \_\_\_\_\_

5. Does your child have any sleeping problems? \_\_\_\_\_

6. What does your child call the washroom when needing it? \_\_\_\_\_

7. Is there anything else you would like us to know about your child that would be helpful to us?

\_\_\_\_\_  
\_\_\_\_\_