St. Catherine of Sweden Church Preschool
2554 Wildwood Road
Allison Park, Pa 15101

Registration Form

Date of Enrollment:_____ Session: Morning/ Afternoon/Either/Montessori 9-2:30
Mommy and Me/ 3 year/ 4 year/ Pre-K/Primary Montessori

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

Name Child would like to be called by_____

Full name of Mother:_____

Full name of Father:_____

Family Email Address (that you check Daily)_____
(If you don't give this info paper work will be mailed to you or in your child's Bag)

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 in case 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 fee 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 know 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/Dietary Needs 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)