DATE:__________

342 Dorseyville Rd. ◆ Pittsburgh, PA 15215
412-963-8885

REGISTRATION FORM

$40.00 registration fee (non-refundable) must be returned with your completed Registration Form

Name of the Parish/Church I am registered in:______________________________

(Please check one) I am applying to have my child registered in the following class:

☐ **Little Dippers** (Mon./Wed. 9am-10:30am) **Child must be 2 years old by Sept. 1**

☐ **Blue Big Dippers** (Tues./Wed./Thurs. 9:15am-11:45am) **Child must be 3 years old by Sept. 1**
We may be able to offer a two-day (Tues/Thurs) Big Dippers class, 9am-12:45pm). If the two-day class would be your **FIRST** choice, please check here: ☐ *

☐ **Shooting Stars** (Mon./Tues./Wed./Thurs. 9am-11:30am) **Child must be 4 years old by Sept. 1**

1. CHILD ☐ **Male** ☐ **Female**

First Name ______________ Middle __________ Last ______________

Child's Birth Date ____________ Name you would like your child **called** ______________

Name you would like your child to learn to **copy & trace**______________________
(This name is used for cubbies, sign in, name tags, school work, etc.)

2. MOTHER

First Name______________ Middle __________ Last ______________

Address__________________________ Home Phone ______________

__________________________ Zip Code______________

E-mail __________________________ Cell Phone ______________

Occupation __________________________ Work Hours ______________

Where Employed__________________________ Work Phone ______________

3. FATHER

First______________ Middle __________ Last ______________

Address/Home Phone (if different from above)______________________________

E-mail __________________________ (if you wish to have Weekly Updates sent to you as well)

Occupation __________________________ Cell Phone ______________

Where Employed__________________________ Work Phone ______________

*2-day (Tues./Thurs.) session for Big Dippers would have the same number of hours as the 3-day session.

(Please complete other side)

4. AUTHORIZED ADULTS

For your child's safety, please list below the adults authorized to provide transportation for your child:

Name______________________________ Phone______________________

Name______________________________ Phone______________________

5. EMERGENCY INFORMATION

Name of person authorized to act for parent/guardian in an emergency (if parent/guardian is unavailable):

Name______________________________ Home Phone ______________________

Address______________________________ Cell Phone ______________________

Where Employed______________________________ Work Hours ______________________

Work Phone ______________________________

Name of Physician ______________________________ Office Phone ______________________

Address______________________________

Name of Dentist ______________________________ Office Phone ______________________

Address______________________________

6. BACKGROUND INFORMATION

Allergies (foods, medicines, animals, etc.) ______________________________

Medical Conditions/Educational Needs (chronic illnesses, premature birth, wears glasses, asthma, etc.) __

____

Has your child received early intervention services (Alliance or DART)? If so, do they have a current IEP?

____

____

Other children in the family:

NAME	BIRTHDATE	SCHOOL

7. I DO HEREBY AUTHORIZE EMERGENCY MEDICAL CARE FOR MY CHILD.

____

____

All information will be kept confidential.