

*St. Michael the Archangel Preschool*

14201 Nall Avenue, Leawood, Kansas 66223; Johnson County  
License Number: 0057102-008

**STUDENT INFORMATION FORM  
2021-2022 SCHOOL YEAR**

Child's Full Name: \_\_\_\_\_ Male / Female Preferred Name at School: \_\_\_\_\_

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

Preferred family email address: \_\_\_\_\_

Any know allergies & reaction: \_\_\_\_\_ St. Michael the Archangel Parishioners? **YES or NO**

Has your child ever received Services for: Physical Therapy \_\_\_\_\_ Occupational Therapy \_\_\_\_\_ Speech Therapy \_\_\_\_\_

Does your child have an Individualized Education Plan (IEP)? \_\_\_\_\_ Yes \_\_\_\_\_ No

School District: \_\_\_\_\_ Services Received: \_\_\_\_\_

Student Lives With: \_\_\_\_\_ Both Parents \_\_\_\_\_ Mother \_\_\_\_\_ Father

Mother's Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Step Parent or Guardian (please specify if applicable)

Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Are there any considerations in which the school should be made aware?** (Marital, Educational, Custodial, etc?)

Please specify the child and the consideration. (Attach additional paper if needed.)

(Over)

**The following have authority and have agreed to pick up my child/children at school if either parent/guardian cannot be reached. (Please include older siblings who have authority to transport your child.)**

Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Health concerns:** In accordance with the St. Michael Parent Handbook, please list all health needs, concerns, or other necessary information to better care for your child.

**Is your child taking any daily medications?** (Prescription or Over-the-Counter)

Medication	Dose/How is it taken	Time
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Medication	Dose/How is it taken	Time
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**I give permission for the director to share any health related information with the teachers/staff as needed: \_\_\_YES \_\_\_NO**

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**Permission /Authorization**

***Initial Each in Agreement:***

\_\_\_\_\_ **Authorization for Emergency Medical Care:** I hereby authorize Jennie Wentz, Director and/or SMTA Preschool Staff who is/are representatives of the above named facility to give consent for any and all necessary emergency medical care for my child.

If child is covered by health insurance, provide the following:

Health Insurance Company Name: \_\_\_\_\_

Medical Assistance Program: \_\_\_\_\_

Policy or Group Number: \_\_\_\_\_

Card or ID Number: \_\_\_\_\_

Military Medical Care I.D. \_\_\_\_\_

\_\_\_\_\_ **Media Permission:** I hereby consent to my child being interviewed, photographed, and/or videotaped by representatives of St. Michael the Archangel Parish, its agents, and independent contractors. Any information or images obtained from those activities may be reproduced by the parish and/or the public media for use in advertising, publicity, or educational activities; including, but not limited to, parish publications and/or videos, print and television news and Parish websites. I hereby waive any claims I may have and release the parish and its employees from any liability or claims arising out of such activities.

\_\_\_\_\_ **Preschool Directory:** I hereby consent to have my child's contact information printed in a directory format for the purpose of organizing social activities outside of the preschool environment, i.e. play dates, birthday parties. Each family will receive a copy of the preschool directory.

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

\_\_\_\_\_  
Date