

REGISTRATION FOR NIXON PRESCHOOL

CHILDS NAME _____ NICKNAME _____

BIRTHDATE _____ (Please attach a copy of birth certificate.)

ADDRESS _____

PHONE NUMBER _____

FATHER'S NAME _____

FATHER'S ADDRESS _____

FATHER'S PHONE # _____ WORK PHONE # _____

FATHER'S EMPLOYMENT _____

MOTHER'S NAME _____

MOTHER'S ADDRESS _____

MOTHER'S PHONE # _____ WORK PHONE # _____

MOTHER'S EMPLOYMENT _____

SIBLINGS' NAMES, BIRTHDATES, AND SCHOOLS:

PLEASE CIRCLE YOUR CLASS CHOICE:

3 YEAR OLDS – TUESDAY AND THURSDAY FROM 9:00 – 11:30 A.M. @ \$70.00 / MONTH

4 & 5 YEAR OLDS – MONDAY/WEDNESDAY/FRIDAY FROM 9:00 – 11:30 A.M. @ \$90.00 / MONTH

4 & 5 YEAR OLDS – MONDAY/WEDNESDAY/FRIDAY FROM 12:30 – 3:00 P.M. @ \$90.00 / MONTH

**** \$30.00 NON-REFUNDABLE REGISTRATION FEE PAYABLE UPON REGISTRATION ****

Checks should be made payable to:

Nixon Preschool
334 Airport Road
Butler, PA 16002

DISMISSAL INFORMATION

Please list anyone who will be able to pick up your child from school. Remember to list carpool drivers, babysitters, grandparents, and parents of after school playmates. Your child will not be released to anyone who is not on your list. If someone needs to be added at a later date, please notify the teacher in writing. Thank you.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

What kinds of activities would you like your child to experience this year?

List your child's interests and favorite things: _____

How did you hear about Nixon Preschool? _____

May we include your child's name, parents' names, address and phone number in a class directory that would be given out to all the families in your child's class? YES NO

Signature of Parent/Guardian

Date

**NIXON PRESCHOOL
EMERGENCY TREATMENT FORM**

STUDENT'S NAME _____

HOME PHONE NUMBER _____

ADDRESS _____

FATHER'S NAME _____ WORK PHONE # _____

MOTHER'S NAME _____ WORK PHONE # _____

IN THE EVENT OF AN EMERGENCY EVERY EFFORT WILL BE MADE TO CONTACT THE PARENTS FIRST. IN CASE OF SUDDEN ILLNESS OR AN ACCIDENT IN THE SCHOOL AND WE ARE UNABLE TO REACH THE PARENTS, PLEASE CALL:

RELATIVE OR FRIEND _____ PHONE # _____

RELATIVE OR FRIEND _____ PHONE # _____

FAMILY PHYSICIAN _____ PHONE # _____

FAMILY DENTIST _____ PHONE # _____

MEDICAL INSURANCE CARRIER _____

POLICY # _____

DOES YOUR CHILD HAVE ANY UNUSUAL HEALTH CONDITIONS? (DIABETIC, HEART CONDITION, ALLERGIES, ETC.)?

DOES YOUR CHILD HAVE ANY DIETARY RESTRICTIONS OR ALLERGIES?

IF MY CHILD NEEDS IMMEDIATE MEDICAL ATTENTION AND THE SCHOOL IS UNABLE TO CONTACT HIS/HER PARENTS OR THE FAMILY DOCTOR, YOU HAVE MY PERMISSION TO TAKE MY CHILD TO THE EMERGENCY ROOM AT A LOCAL HOSPITAL FOR TREATMENT.

Signature of Parent or Guardian

Date

* If it would be necessary for the teachers to administer medication to your child during preschool hours, please request the "Procedure for Administering Medication" permission slip and have it completed by your child's physician.

**NIXON PRESCHOOL
IMMUNIZATION RECORD**

Please have your doctor complete the following immunization form (listing inoculation dates) and return to the school. We **must** have the Physician's signature on the bottom of this form.

CHILD'S NAME _____
(FIRST NAME) (MIDDLE) (LAST NAME)

DPT (DIPHtheria – PERTUSIS – TETANUS)

DATE

1ST (2 months) _____
2ND (4 months) _____
3RD (6 months) _____
Booster _____
Booster _____

TOPV (TRIVALENT ORAL POLIO VACCINE)

DATE

1ST (2 months) _____
2ND (4 months) _____
3RD (18 months) _____
4TH (4 – 6 years) _____

MMR (MEASLES – MUMPS – RUBELLA)

DATE

1ST (15 months) _____

HIB (HEMOPHILUS INFLUENZA B)

DATE

1ST (6 months) _____
2ND (12 months) _____
3RD (15 months) _____

TUBERCULIN TEST

PLEASE DESCRIBE ANY MEDICAL INFORMATION PERTINENT TO
DIAGNOSIS AND TREATMENT IN CASE OF EMERGENCY DURING
PRESCHOOL HOURS

Signature of Doctor

Date