Pre-K Registration Form

Teacher _____

2013- 2014 School Year

Bus # _____

Child's Information		
Child's Last Name:	First:	Middle Initial:
Social Security #:	D.O.B.(MM-DD-YYYY):	Sex: ( ) M ( ) F
Home Address:		
City:	State: AR Zip:	Home: ( )
Check One ( ) Bus Rider ( ) Car rider ( ) Daycare	Race (Circle One): White Black Hispanic Other:	

Parent/Guardian			
Primary Care Giver's Last Name:	First:	Middle Initial:	
Home Address (If different from child's)			
City:	State:	Zip:	
Social Security #:	D.O.B.(MM-DD-YYYY):	Sex: ( ) M ( ) F	
Home Phone: ( )	Work Phone: ( )	Cell: ( )	
Place of Employment:		Full-time / Part-time	
Address:	City:	State:	Zip:
Secondary Care Giver's Last Name:	First:	Middle Initial:	
Home Address (If different from child's)			
City:	State:	Zip:	
Social Security #:	D.O.B.(MM-DD-YYYY):	Sex: ( ) M ( ) F	
Home Phone: ( )	Work Phone: ( )	Cell: ( )	
Place of Employment:		Full-time / Part-time	
Address:	City:	State:	Zip:

Child Maintenance				
Child's Living Arrangements:	( ) Both Parents	( ) Mother	( ) Father	( ) Other
Child's Legal Guardian:	( ) Both Parents	( ) Mother	( ) Father	( ) Other

Household Information - List ALL Family Members Living in Household INCLUDING the PRE-K Child

How many people live in your household?_____

Name	Relationship	Age	Date of Birth

PLEASE COMPLETE SIDE 2

Emergency Information:			
Name:		Relationship to Student:	
Day Time Address:		City:	State: Zip:
Home Phone: ( )	Day Time Phone ( )		Cell:( )

This child may be released to the persons listed on Side 1 or to the following:		
Name:	Address:	Phone: ( )
Name:	Address:	Phone: ( )
Name:	Address:	Phone: ( )
Name:	Address:	Phone: ( )
Name:	Address:	Phone: ( )
Name:	Address:	Phone: ( )

Medical
Child's Physician or Clinic's Name (Child's Primary Health Source): Phone:
My child has the following special need(s):
The following special accommodations(s) may be required to most effectively meet my child's needs while at this center:
My child is currently on medication(s) prescribed for long-term continuous use and/or has the following pre-existing
allergies, illness, or health concerns:
Preferred Hospital:

IN THE EVENT PHYSICIANS, OTHER PERSONS NAMED ON THIS FORM, OR GUARDIANS CANNOT BE CONTACTED, SCHOOL OFFICIALS ARE HEREBY AUTHORIZED TO TAKE WHATEVER ACTION IS DEEMED NECESSARY IN THEIR JUDGMENT FOR THE HEALTH OF THE ABOVE STUDENT. I WILL NOT HOLD THE SCHOOL DISTRICT FINANCIALLY RESPONSIBLE FOR THE EMERGENCY CARE AND/OR TRANSPORTATION. I AUTHORIZE CABOT SCHOOLS TO PROVIDE EMERGENCY MEDICAL CARE.

(Circle One) YES NO **Parent/Guardian Signature** _____

Do you live in Federally Funded Low Rent Housing? (Circle One) YES NO

Is either parent/guardian an employee of the Uniformed Military Services, LRAFB Civilian Service, VA Medical Center, Pine Bluff Arsenal, Job Corp, Post Office, or Federal Office Building?
(Circle One) YES NO If Yes, which of the following? Uniformed _____ Non-Uniformed ____

Are you receiving child care assistance from DHS? (Circle One) YES NO

Primary Language spoken in the home: English _____ Other _____

I verify the above information to be correct, and I understand that completion of this form does not guarantee placement in a Pre-K class. If my child is placed in the Pre-Kindergarten Program, I agree that my child will attend the program for 7 hours each day, 5 days a week, for the 180-day school year. I understand that failure to comply with these attendance requirements could result in my child being excused from the program. I understand that I cannot register my child without a completed enrollment package.

Signature Parent/Guardian: _____ Date: _____

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