



# Pre-K Registration Form

Teacher \_\_\_\_\_

2018- 2019 School Year

Bus # \_\_\_\_\_

**Child's Information**

Child's Last Name:	First:	Middle Initial:
Social Security #:	D.O.B.(MM-DD-YYYY):	Gender: ( ) M ( ) F
Home Address:		
City:	State: AR	Zip: Home: ( )
Check One ( ) Bus Rider ( ) Car rider ( ) Daycare		
Race (Circle One): White Black Hispanic Other:		
Does your child receive any services ( ) YES ( ) NO If yes, for what? ( ) Speech ( ) OT ( ) PT ( ) Developmental		

**Parent/Guardian (Parent or guardian with most contact with child)**

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):	Gender: ( ) M ( ) F
Home Phone: ( )	Work Phone: ( )	Cell: ( )
Email Address:		
Place of Employment:	Full-time / Part-time	
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):	Gender: ( ) M ( ) F
Home Phone: ( )	Work Phone: ( )	Cell: ( )
Email Address:		
Place of Employment:	Full-time / Part-time	
<b>* PLEASE NOTE: If you are not employed, you must complete a notarized No Income Statement with this office</b>		

**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** \_\_\_\_\_

I acknowledge I must provide an up to date shot record, including four year old shots, and a physical form completed by a doctor **prior to August 1st**, in order for my child to attend school. These documents will be turned in to the Cabot Administrative Office. Failure to turn these in may inhibit student enrollment.

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

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:** \_\_\_\_\_