

### STUDENT REGISTRATION FORM

**Student's Full Name** \_\_\_\_\_

Name Child will use in school (Matthew, Matt) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Enrollment Date: \_\_\_\_\_

Which class would you like, if available?

3-year old (T/TH) AM \_\_\_\_\_ 4-year old (M/W/F) AM \_\_\_\_\_

3/4-year old PM \_\_\_\_\_ Which Days (PM class only)?: \_\_\_\_\_

Is child baptized? \_\_\_\_\_ Church Where Baptized \_\_\_\_\_

Church home \_\_\_\_\_

**Mother's Name** \_\_\_\_\_

Address \_\_\_\_\_

Street City Zip

Employer \_\_\_\_\_

Address \_\_\_\_\_

Street City Zip

Mother's Phone \_\_\_\_\_ Work number \_\_\_\_\_

**Email Address** \_\_\_\_\_

Receive weekly school emails? Yes No

**Father's Name** \_\_\_\_\_

Address \_\_\_\_\_

Street City Zip

Employer \_\_\_\_\_

Address \_\_\_\_\_

Street City Zip

Father's Phone \_\_\_\_\_ Work number \_\_\_\_\_

**Email Address** \_\_\_\_\_

Receive weekly school emails? Yes No

Brothers and Sisters (Names and Ages)

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

What is the best way to reach you when your child is in our care?

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Why would you like to enroll your child at Lord of Life Lutheran Preschool?

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Are there any special things we should know about your child?

(Afraid of anything, bathroom habits)

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What goals would you like your child to achieve this year?

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Anything else you would like us to know?

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**HANDBOOK FORM**

We have read and understand all materials presented in the Lord of Life Preschool Handbook.

x\_\_\_\_\_

Signature

Date

## HEALTH RESOURCES

Does your child have a medical home?	Yes	No
Has your child had a vision screening?	Yes	No
Has your child had a hearing screening?	Yes	No
Has your child had a dental screening?	Yes	No

If no, below are resources for a medical home (doctor) and the screenings.

### Dental

BENESH, LAURA, DDS  
MODERN DENTAL  
PROFESSIONALS CO PC  
951 E 120TH AVE STE D  
THORNTON, CO 80233  
[\(303\)305-4466](tel:(303)305-4466)

GIVAN, CARL E, DDS  
CARL GIVAN  
3901 E 112TH AVE UNIT G  
THORNTON, CO 80233  
[\(303\)451-1674](tel:(303)451-1674)

ACEVEDO, ALEXANDER P, DDS  
SEDONA DENTAL ASSOCIATES  
905 W 124TH AVE STE 170  
WESTMINSTER, CO 80234  
[\(303\)452-3982](tel:(303)452-3982)

### Medical Home

<https://healthy.kaiserpermanente.org/shop-plans>

### Hearing

Affordable Hearing Center

<https://www.affordablehearingnorthglenn.com/>

### Vision

Vista Eye Care

<http://www.vistaeyecareco.com/>

## AUTHORIZED PICK UP

The following people have authorization to pick my child up from school.

Name	Address	Phone
1. _____	_____	_____
_____	_____	_____
2. _____	_____	_____
_____	_____	_____
3. _____	_____	_____
_____	_____	_____

X \_\_\_\_\_  
Signature of Father

and/or

X \_\_\_\_\_  
Signature of Mother

**Please obtain an official copy of your child's immunization record that is signed by your health-care provider. Return it with your enrollment packet.**

**Please submit a \$50 registration fee/family (cash or check made payable to Lord of Life Lutheran School) with your enrollment packet.**

## EMERGENCY MEDICAL TREATMENT CONSENT FORM

**Child's Name:** \_\_\_\_\_

**Birth Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Parent Name(s):** \_\_\_\_\_

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

**Mother Emergency Contact Number:** \_\_\_\_\_

**Father Emergency Contact Number:** \_\_\_\_\_

In the event that my child, \_\_\_\_\_, sustains a serious or life threatening injury while at the school, I give the school permission to seek emergency medical care for my child.

X \_\_\_\_\_

Parent Signature

Date

### EMERGENCY CONTACT INFORMATION

In case of an emergency and we the parents/guardians cannot be immediately reached, the following people may be contacted in the order listed below. My child can be released to the following individuals.

Name/Relationship

Address

Phone

1. \_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_

**HEALTH CARE PROVIDER INFORMATION**  
***PLEASE FILL OUT COMPLETELY AND SIGN BELOW***

Child's Physician \_\_\_\_\_

Name

Address

Phone

Child's Dentist \_\_\_\_\_

Name

Address

Phone

Hospital Choice \_\_\_\_\_

**CHILD'S HEALTH INFORMATION**

Briefly tell about your child's general health:

\_\_\_\_\_  
\_\_\_\_\_

Any chronic medical problems? \_\_\_\_\_

\_\_\_\_\_

Any allergies? \_\_\_\_\_

\_\_\_\_\_

Any diet restrictions? \_\_\_\_\_

\_\_\_\_\_

**CHILD'S STATEMENT OF HEALTH STATUS FOR ENROLLMENT IN A CHILD CARE FACILITY**

The child care facility must obtain for every child who enrolls in child care programs a signed and dated statement of the child's current health status which indicates the child's abilities and/or limitations to participate in a regularly schedule child care program. This report is to be filled out by a licensed physician or other health care professional who has seen the child in the last twelve months.

Name of Facility Lord of Life Lutheran School Type of Facility Preschool

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Past illnesses - check those the child has had and give approximate dates:

Chicken Pox \_\_\_\_\_ Rubeola \_\_\_\_\_ Rubella \_\_\_\_\_ Rheumatic Fever \_\_\_\_\_ Asthma \_\_\_\_\_

Hay Fever \_\_\_\_\_ Diabetes \_\_\_\_\_ Mumps \_\_\_\_\_ Epilepsy \_\_\_\_\_ Whooping Cough \_\_\_\_\_

Poliomyelitis \_\_\_\_\_ Other \_\_\_\_\_

Comments \_\_\_\_\_

Surgery/Accidents/Illness/Chronic Health Problems

\_\_\_\_\_  
\_\_\_\_\_

Describe any physical condition requiring the facility's special attention:

\_\_\_\_\_  
\_\_\_\_\_

Medication(s) prescribed: \_\_\_\_\_

Allergies: \_\_\_\_\_ and prescribed routine \_\_\_\_\_

If tuberculin test given: Date \_\_\_\_\_ Result \_\_\_\_\_

If chest x-ray taken: Date \_\_\_\_\_ Result \_\_\_\_\_

Vision \_\_\_\_\_ Hearing \_\_\_\_\_

Please record immunizations and date administered on the Colorado Department of Health Certificate of Immunization and attach to this form.

Date of my recent examination of the child: \_\_\_\_\_

X \_\_\_\_\_

**Signature of licensed physician or other health care professional**

\_\_\_\_\_ **Date**

Please Print:

Name of Physician/Health Care Professional \_\_\_\_\_

Address City State Zip \_\_\_\_\_

Phone \_\_\_\_\_