School Year: 201___-201____

# STUDENT REGISTRATION FORM

## Student's Full Name _____

Name Child will use in school (Matthew, Matt) _____

**Date of Birth** _____ Enrollment Date: _____

Is child baptized? _____Church Where Baptized _____

Church home _____

**Please indicate days and times you would like to enroll:**

*Mark both AM & PM on same day for Full Day Preschool option.*

| | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |
|---|---|---|---|---|---|
| **AM** | | | | | |
| **PM** | | | | | |

## 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?

_____

_____

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

_____

_____

Are there any special things we should know about your child?
(Afraid of anything, bathroom habits)

_____

_____

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

_____

_____

Anything else you would like us to know?

_____

_____

_____

_____

**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

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

ACEVEDO, ALEXANDER P, DDS
SEDONA DENTAL ASSOCIATES
905 W 124TH AVE STE 170
WESTMINSTER, CO 80234
(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_____ X _____

Signature of Father and/or 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 <u>Lord of Life Lutheran School</u>) 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_____