

PRESCHOOL STUDENT ENROLLMENT

School: _____ School Year: _____

STUDENT

Legal Last Name: _____ Legal First Name: _____ Legal Middle Name: _____

Nickname: _____ Birthday: _____ Gender: Male Female

Are you Hispanic/Latino? No Yes

Which of the following groups describe the student's race?)* **(You must select at least one race)**

- American Indian Asian Black Native Hawaiian/Pacific Islander White

Student may be picked up by: Mother Father Step-Mother Step-Father Other, name _____

Designated Neighborhood School/District? _____

Is this student attending on a non-immigrant VISA? No Yes If yes, list type of VISA _____

Has this student ever received an IEP/special education services, such as speech, occupational therapy, etc.? No Yes
 If yes, is this student currently receiving special education services under an IEP? No Yes

Child lives with: Both Parents in same household OR Joint Custody OR Mother Only OR Father Only OR
 Other (specify) _____

Primary Language Spoken at Home: English Spanish Other _____

Adult #1 – Relationship to Student: Mother Father Step-Mother Step-Father Other

Which of the following designations and access should this person receive in regards to the student:
 Guardian Receive Mailings Portal Access Messenger

Adult #2 – Relationship to Student: Mother Father Step-Mother Step-Father Other

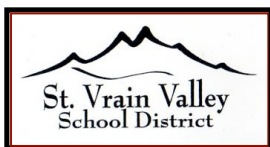
Which of the following designations and access should this person receive in regards to the student:
 Guardian Receive Mailings Portal Access Messenger

Adult #3 – Relationship to Student: Mother Father Step-Mother Step-Father Other

Which of the following designations and access should this person receive in regards to the student:
 Guardian Receive Mailings Portal Access Messenger

Adult #4 – Relationship to Student: Mother Father Step-Mother Step-Father Other

Which of the following designations and access should this person receive in regards to the student:
 Guardian Receive Mailings Portal Access Messenger



PRESCHOOL STUDENT ENROLLMENT

PERMISSIONS

I give permission to have my child photographed for school pictures. No Yes

I give permission to have my child participate in news media coverage including honor roll publication. No Yes

I give permission for the St. Vrain Valley School District (and any person or company authorized by the District) to use and copyright all photographs, film, video, and/or recordings taken of this student by District staff (or their representatives) and understand that the District may use reproductions, alterations, or additions to them. I also understand that these reproductions may include authorized District websites and school district publications. No Yes

EMERGENCY CONTACTS: Please provide at least one (1) local emergency contact (emergency contacts are not the Parent/Guardian).

Contact #1 Name: _____ Relationship to Student: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Contact #2 Name: _____ Relationship to Student: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Contact #3 Name: _____ Relationship to Student: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Doctor Name _____ Phone: _____ Gender: oMale oFemale

Name of Practice/Group: _____ Address: _____

Dentist Name _____ Phone: _____ Gender: oMale oFemale

Name of Practice/Group: _____ Address: _____

Hospital of Choice _____ Phone: _____

Address: _____

I authorize, by my signature below, that if the above people cannot be reached, school personnel are authorized to use their best judgments in an emergency situation. The School District does not have medical or dental insurance for students. It is understood that all costs related to emergency treatment will be the responsibility of the parent. As long as the medical treatment considered necessary is in accordance with generally accepted standards of medical practice, I impose no specific prohibitions regarding treatment unless stated.

Parent/Guardian Signature

Date



Northridge Elementary
1200 19th Avenue
Longmont, CO 80501
(303) 772-3040

Preschool Application*
2011-2012

Child's Name _____ Date of Birth** _____
Gender: (Please circle) Male or Female Application Date _____
Parent's Name _____ Phone _____
Address _____ Language spoken at home: _____
City/State/ Zip _____ email _____

**3 year old program: must be 3 on or before October 1, 2011. 4 year old program: must be 4 on or before October 1, 2011.

Please answer the following questions:

- 1. Does the child live in this school's attendance area? Yes___ No___
- 2. Does the child have a sibling in this school? Yes___ No___
- 3. Does the child have a parent on staff at this school? Yes___ No___
- 4. Did the child attend this preschool in the previous year? Yes___ No___ Where? _____

Monthly Tuition (9 months) for all District Preschool Programs:

- \$165.00 2 half-day classes
- \$210.00 3 half-day classes
- \$265.00 4 half-day classes

Upon notification of acceptance into a program, a non-refundable \$65.00 registration fee is required with the completed registration packet.

Please indicate your 1st & 2nd choice from the following programs offered at this location:

- ___ 3 & 4 year old class: Monday - Thursday AM
- ___ 3 & 4 year old class: Monday - Thursday PM

Classes must meet minimum capacity. The District reserves the right to modify class sections based on enrollment.

For additional preschool questions go to the District Preschool Website (www.stvrain.k12.co.us/preschool) or contact Ellen Cooper at:

Early Childhood District Office
303-702-7815 or 303-772-7700 Ext. 7863

*Families may apply to more than one preschool however; enrollment is limited to one district program.



General Health Appraisal Form

Parent: *Please complete*

Child's name _____ Gender _____ Date of Birth _____

Address _____ Phone _____

Mother/ Guardian Name _____ Father/ Guardian Name _____

Allergies _____

Drug Reactions _____

Illnesses (Check illnesses the child has had and give approximate dates)

Chicken Pox _____ Rubeola _____ Asthma _____

Mumps _____ Rubella _____ Epilepsy _____

Polio _____ Rheumatic Fever _____ Diabetes _____

Strep Throat _____ Whooping Cough _____ Other _____

Surgeries/ Accidents/ Chronic or Disability Conditions _____

Describe any **special requirements** for which your child may need assistance from preschool staff: _____

Immunizations up to date: Yes ___ No ___ (Copy of records must be given to the preschool **before** child may attend.)

Parent or Legal Guardian Signature _____

Date: _____

Authorization expires 365 days after this date

Health Care Provider: *Please complete after parent section has been completed*

Date of Last Exam: _____ Recent Weight: _____ Recent Height: _____

Physical Exam: Normal _____ Abnormal: _____ (see explanation of significant health concerns:)

Significant Health Concerns: None _____

Describe any **physical condition** requiring special attention by the preschool staff _____

If tuberculin test given: Date _____ Result: _____ If chest x-ray given: Date _____ Result: _____

Current Medications/ Special Diet: ___ None ___ Describe: _____

(Separate medication authorization form required for medications given at school.)

Signature: *Licensed Physician or Nurse Practitioner*

Date of Next Well Visit: _____

This child's health status allows participation in all preschool activities. Any concerns or exceptions are identified on this form.

Date _____

Signature of Health Care Provider (certifying form was reviewed.)

Office Stamp: *name, address, phone #*