

EDISON LOCAL SCHOOL DISTRICT

PRESCHOOL APPLICATION

County _____ Site _____

Child's name _____

Sex: ___Male ___Female Birth Date _____ Verified by _____

Parent(s) or Legal Guardian _____

Residence Address _____

Number Street City State Zip

Mailing Address _____

Enter "Same" if identical to Residence

Family Phone _____ Nearest Phone _____

Child's Social Security # _____ Child's Medicaid # _____ 0

MEMBERS IN CHILD'S HOUSEHOLD

Name	Relationship	Sex	Birth Date	Social Sec.#	Education	Handicap

Total Number in Household _____

SOURCE OF INCOME (Check appropriate lines)

Employment _____ Other _____

Social Security _____ Support _____

Work Comp. _____ ADC _____

Unemployment _____ Alimony _____

HEALTH PROBLEMS

To the best of your knowledge does your child have any of the following:

Speech _____ Hearing _____

Handicapped _____ Other _____

Type of Handicap _____

MONTHLY AMOUNT _____

YEARLY AMOUNT _____

Office of Early Learning and School Readiness

CHILD ENROLLMENT INFORMATION

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Child's Name _____ Date of Birth _____
 Address _____ Home Phone _____
 Parent/Guardian Name _____ Cell phone _____
 Home Address _____ Home Phone _____
 Employer name & address _____ Work Phone _____

Please circle which phone number should be used 1st 2nd 3rd to reach you while your child is in the program.
 Cell 1 2 3 Home 1 2 3 Work 1 2 3

Employer Address _____
 Parent/Guardian Name _____ Cell Phone _____
 Home Address _____ Home Phone _____
 Employer name & address _____ Work Phone _____

Please circle which phone number should be used 1st 2nd & 3rd to reach you while your child is in the program.
 Cell 1 2 3 Home 1 2 3 Work 1 2 3

Please list two people to be contacted in the event of an emergency if the parent cannot be contacted:

Name	Name
Street Address	Street address
City	City
State Zip code	State Zip code
Relationship to Child	Relationship to Child
Home phone:	Home phone:
Cell phone:	Cell phone:
Work Phone:	Work Phone:

Physician:	Dentist:
Name	Name
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code
Phone	Phone

Please complete both sides of this form

ANNUAL CLASS ROSTER

Each year we prepare a roster for each group of children in our program.
 This roster will not be furnished to any persons other than parents of children enrolled in our program.

I authorize the following to be listed on the parent roster.

Please circle one

My child's name	Yes	No
Parents/Guardians name	Yes	No
Phone number	Work	Mobil Home
	No	No

Date: _____

Signature of parent, or guardian. _____

CHRONIC PHYSICAL PROBLEM (S):
HISTORY OF HOSPITALIZATION:
DISEASES THIS CHILD HAS HAD:
ALLERGIES AND TREATMENT:
MEDICATIONS, FOOD SUPPLEMENTS, MODIFIED DIET OR FLUORIDE SUPPLEMENTS:

List of Person(s) to whom this child can be released: (Please print)

List of Person(s) not permitted to pick up this child (Please print)

	Restraint papers or Divorce decree attached
	Yes No
	Yes No

IMPORTANT: Please attach a copy of your child's Immunization records

EXEMPT FROM IMMUNIZATIONS	PLEASE CIRCLE ONE	
	YES	NO
Religious conviction		
Other:		

Parent/Guardians signature for immunization exemption: _____