



# Pikeville United Methodist Church Preschool

## "GENESIS KIDS"

*"The beginning of a lifelong journey of faith and learning"*

107 Main Street - Post Office Box 311 -Pikeville, Kentucky 41502

606.437-7315

[www.pikevilleumc.org](http://www.pikevilleumc.org)

Received: _____
Check # _____
BC <input type="checkbox"/> Physical <input type="checkbox"/> Immun. <input type="checkbox"/>
Office Use Only

### APPLICATION FOR ADMISSION INTO THE PRESCHOOL PROGRAM

The following information is important to us. Each item needs to be answered. This will help the teachers understand your child and be able to better meet his/her needs. This application is held in confidence by the teachers, and filed in a secure place. **We must have a copy of the child's birth certificate immunization record and physical on file for your child's record to be complete.** *Incomplete forms will be returned.*

**CHILD'S FULL NAME** \_\_\_\_\_ **BIRTH DATE** \_\_\_\_\_

What name will your child use in school? \_\_\_\_\_ Male  Female

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

911 Address (if different from above) \_\_\_\_\_

### PARENT/GUARDIAN INFORMATION

FATHER	
Name	_____
Marital Status	_____
Address if Different	_____
Place of Employment	_____
Work Address	_____
<b>PHONE:</b>	
Home	_____
Cell	_____
Work	_____
E-mail	_____

MOTHER with Maiden Name	
Name	_____
Marital Status	_____
Address if Different	_____
Place of Employment	_____
Work Address	_____
<b>PHONE:</b>	
Home	_____
Cell	_____
Work	_____
E-mail	_____

### PERSON PERMITTED TO PICK UP CHILD OTHER THAN PARENT

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>ADDRESS</u>	<u>PHONE</u>

### NAME OF PERSONS WHO ARE NOT PERMITTED TO PICK UP YOUR CHILD

If there is a separation or divorce custody problems of which we should be aware, please explain:

*(revised 2009)*



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### SOCIAL INFORMATION

Name your child responds to \_\_\_\_\_

#### THESE PERSONS LIVE WITH ME:

NAME	RELATION TO ME	LIST AGE OF SIBLINGS

What kind of group experience has your child had? \_\_\_\_\_

\_\_\_\_\_

Are your child's playmates (select all that apply) - Girls  Boys  Younger  Older

Does he/she accept new people easily? \_\_\_\_\_

Does he/she have any particular fears? \_\_\_\_\_

\_\_\_\_\_

Nervous habits? \_\_\_\_\_

\_\_\_\_\_

Is there any area which you feel requires particular attention? (kicking, biting, etc.)

\_\_\_\_\_

When you find it necessary to discipline your child, what is the discipline? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other comments or special instructions? \_\_\_\_\_

\_\_\_\_\_



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### PHYSICAL INFORMATION

Does your child have any unusual eating problems, food preferences or dislikes?

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

Special medications? \_\_\_\_\_

How does he/she state his/her need to go to the bathroom?

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Other comments or special instructions \_\_\_\_\_

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Please describe your child's likes and dislikes \_\_\_\_\_

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What do you expect your child to gain from this preschool experience? \_\_\_\_\_

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### **HEALTH FORM TO BE FILLED OUT BY PARENT**

Name of Child \_\_\_\_\_ Sex \_\_\_\_\_ DOB \_\_\_\_\_

#### **Family Medical History:**

Is there any family history of disease such as tuberculosis, rheumatic fever, convulsive disorder, etc?

Yes  No

If yes, specify \_\_\_\_\_

\_\_\_\_\_

#### **PERSONAL MEDICAL HISTORY:**

Has the child ever been seriously ill? \_\_\_\_\_ If yes, please give details \_\_\_\_\_

\_\_\_\_\_

What childhood disease(s) has the child had? \_\_\_\_\_

Are there any allergies? \_\_\_\_\_

Does the child hear well? \_\_\_\_\_

Is there any visual difficulty? \_\_\_\_\_

Is there any speech difficulty? \_\_\_\_\_

Are there any physical special needs? \_\_\_\_\_

Is your child a picky eater? \_\_\_\_\_

Does he/she sleep at least eight hours each night? \_\_\_\_\_

Name of child's physician \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_



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## Field Trip Permission Slip

**I GIVE** permission for my child \_\_\_\_\_ to leave the preschool building for trips to the park, walks within the city (i.e. trick or treating) and to take trips in the church van. *You will always be informed before these trips are taken.*

**I DO NOT GIVE** permission for my child \_\_\_\_\_ to leave the preschool building for trips to the park, walks within the city (i.e. trick or treating) and to take trips in the church bus.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian



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**PARENTAL EMERGENCY/MEDICAL CONSENT**

Permission for medical care in parental absence. (This form must be presented upon admission for treatment.)

CHILD'S FULL NAME: \_\_\_\_\_

In the event that my child may require emergency medical and /or surgical care while I am out of the city or unable to be reached, I hereby give my consent to medical and/or surgical treatment to the

\_\_\_\_\_ and doctor \_\_\_\_\_

to provide this care. I agree to pay all costs as secured or authorized under this consent.

Signature of parent/legal guardian X \_\_\_\_\_

Printed name of parent/legal guardian \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work and/or Cell Phone \_\_\_\_\_

Doctor \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_

Hospital of preference \_\_\_\_\_

Person(s) to be contacted in emergency if parents are unavailable:

NAME	RELATIONSHIP	HOME PHONE	WORK PHONE

This consent will be in effect beginning our first day of school and continuing while the child is enrolled at this preschool.

**(TO BE FILLED OUT BY THE CHILD'S PHYSICIAN)**

**PHYSICAL EXAMINATION:**

Child's Name \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

General Vitality \_\_\_\_\_ Any abnormality of Skin \_\_\_\_\_

Glands \_\_\_\_\_ Head \_\_\_\_\_ Eyes \_\_\_\_\_

Ears \_\_\_\_\_ Nose \_\_\_\_\_ Throat \_\_\_\_\_

Lungs \_\_\_\_\_ Mouth/Teeth \_\_\_\_\_ Heart \_\_\_\_\_

Abdomen \_\_\_\_\_ Genitalia \_\_\_\_\_ Extremities \_\_\_\_\_

Neurological \_\_\_\_\_

If "YES" is answered to any items, give details: \_\_\_\_\_

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

Is these any special medical situation of which the school should be aware? \_\_\_\_\_

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

Any particular emotional or behavioral problem? \_\_\_\_\_

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

\_\_\_\_\_  
Date of Examination

\_\_\_\_\_  
Signature of Physician

*COPY OF IMMUNIZATION RECORD IS REQUIRED ALSO*

*\*Physical exam may be sent in as late as opening of school year.*