2022-2023 School Year Saint Boniface Preschool Application

SAINT BONIFACE Preschool CHRISTIAN • MONTESSORI

Child's Current Age _____ **Please designate your first choice with a #1 and your second choice with a #2.**
We give preference to full day students.

____ ½ Day 3 Days (MWF) Per Week (AM only) ____ Full Day 3 Days (MWF) Per Week

____ ½ Day 5 Days Per Week (AM only) ____ Full Day 5 Days Per Week

Please **PRINT** all information.

CHILD INFORMATION

Name: _____ (Last / First / Middle) Male ☐ Female ☐ Today's Date _____

Date of Birth: _____ (Month) /_____ (Day) /_____ (Year) Birth Certificate No. _____ Place of Birth: _____ (City) _____ (State) Religion/Parish: _____

Address: _____ (House No. / Street / Apt. No. / Lot No. / City / State / Zip / Home Phone # / Cell Phone #)

Child lives with: Both Parents ☐ Mother ☐ Father ☐ Other ☐ Relationship: _____ Legal Custody with: _____ (**Must provide court papers**)

Did child attend another preschool? No ☐ Yes ☐ Name of School (if Yes): _____

FAMILY INFORMATION

	First/Last Name	Home Address	Home Phone #	Place of Employment	Work Address	Work Phone #
Father						
Mother						
Step-Parent						
Step-Parent						
Other						

Other Children Living in Home:

First/Last Name	Relationship to Applicant	Birth Date

Child's Physical Description at Time of Application

Eye Color:	Hair Color:
Height:	Weight:

Over

HEALTH INFORMATION

Does child have health insurance coverage? No ☐ Yes ☐

Name of Physician or Clinic: _____ Phone #: _____

Has child ever had surgery? No ☐ Yes ☐

Type of operation: _____ Date: _____

Does child have allergies? No ☐ Yes ☐ Type: _____

Records were copied on: _____
Date

Initials: _____

Allergy Medication: _____ Food Allergies: _____

Does child have allergies to any medication? No ☐ Yes ☐ Type: _____

List prescription medications child is currently taking: _____

Medical Conditions:

Diabetes:	No ☐	Yes ☐	Heart Problems:	No ☐	Yes ☐
Epilepsy:	No ☐	Yes ☐	Asthma:	No ☐	Yes ☐

Other: _____

OTHER INFORMATION

In order to properly plan for an incoming student, the school needs to know if there is any educational, developmental, psychological, behavioral, social, or medical history that affects the student's learning.

Please check No or Yes if your child has received any of these services. If Yes, please briefly describe.

Early Intervention Program	No ☐	Yes ☐	_____
Developmental History:	No ☐	Yes ☐	_____
Medical History:	No ☐	Yes ☐	_____
Physical Conditions:	No ☐	Yes ☐	_____
Other:	No ☐	Yes ☐	_____

By placing my/our signature(s) below, I/we verify that all information is accurate and complete. I/We realize that failure to provide accurate information about my/our child may jeopardize enrollment at this school. I/We further verify that no information has been omitted.

Parent/Guardian Signature	Please Print Name	Email Address	Date
_____	_____	_____	_____

Parent/Guardian Signature	Please Print Name	Email Address	Date
_____	_____	_____	_____