

St. John's Evangelical Lutheran Church Preschool
Boyertown, PA 19512

Transitional Kindergarten
APPLICATION

Mon., Tue., Wed., Thur., Fri.	9:00 - 11:30	\$265/month
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Child needs to turn 5 by December 31.

Name of Child:

LAST FIRST MIDDLE

Date of Birth: _____ Place of Birth: _____

Street Address _____ M _____ F _____

Town & State: _____ Home Phone: _____

Child Lives With: _____

Father:

Name: _____ Birthdate: _____

Education: _____ Occupation: _____

Place of Employment: _____ Phone: _____

Email: _____

Church Membership _____

Mother:

Name: _____ Birthdate: _____

Education: _____ Occupation: _____

Place of Employment: _____ Phone: _____

Email: _____

Church Membership _____

Brothers and Sisters:

Name

Birthdate

Grade in School

What do you hope your child will gain from this experience? _____

Describe your child, including any special needs (do they receive services, have an IEP etc.), of which the staff should be aware:

Experience with other children:

Previous school experience _____

Sunday Church School _____

Informal Relationships _____

How did you hear about St. John's? _____

E-Mail Address (To be used for billing and parent blasts)—please write clearly

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:
<input type="checkbox"/> I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.		
PARENT'S SIGNATURE:		

DO NOT OMIT ANY INFORMATION
 This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
 NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
 NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
 NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
 NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
 YES NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT [WWW.AAP.ORG](http://www.aap.org))
 YES NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182; 3280.124 (a)(b), 3280.181 & 182; 3290.124 (a)(b), 3290.181 & 182

CHILD'S NAME		BIRTHDATE
ADDRESS		
MOTHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
FATHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
EMERGENCY CONTACT PERSON(S)	NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE
PERSON(S) TO WHOM CHILD MAY BE RELEASED	NAME	ADDRESS
		TELEPHONE NUMBER WHEN CHILD IS IN CARE
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER		TELEPHONE NUMBER
ADDRESS		
SPECIAL DISABILITIES (IF ANY)		ALLERGIES (INCLUDING MEDICATION REACTION)
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION		MEDICATION, SPECIAL CONDITIONS
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD		
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS		POLICY NUMBER (REQUIRED)
PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT		
OBTAINING EMERGENCY MEDICAL CARE		ADMIN. OF MINOR FIRST - AID PROCEDURES
WALKS AND TRIPS		SWIMMING <i>N/A</i>
TRANSPORTATION BY THE FACILITY <i>N/A</i>		WADING <i>N/A</i>

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN

DATE

SIGNATURE OF PARENT or GUARDIAN

DATE

SIGNATURES OF PARENT(S)/GUARDIAN(S)

Application fee (non-refundable) of \$45.00 (\$40.00 prior to 3/15/2022) must accompany this form.

Health record page must be submitted prior to August 31st in order for child to begin school.

In making application for my child, _____ to be enrolled in St. John's Preschool, I/We also give permission for his/her participation in short trips or walks. I/We understand that St. John's Evangelical Lutheran Church and its staff involved in the activity are not responsible in the event of accident or illness. I/We also agree that St. John's may display, on our website or Facebook page, photos of your child during activities.

Signatures: **Father:** _____ **Date:** _____

Mother: _____ **Date:** _____