

# St. Patrick's Preschool

## Application for Admission

2010-2011



Accepting Children  
Ages 2 ½ to 5 Years

Please Return Forms to  
St. Patrick Catholic Church Parish House  
221 West Nelson Street  
Lexington  
(540) 463-6219

[www.stpatrickspreschool.com](http://www.stpatrickspreschool.com)

# St. Patrick's Preschool

On the first day of school your child should bring the forms indicated below. Where documents, such as birth certificates, are requested, please bring the original and we will make copies in the office to keep in your child's file. Forms should be completed and signed by the parent (where applicable).

- Application for enrollment (unless already submitted)
- Birth Certificate (certified copy)
- Baptismal Certificate (if applicable)
- Prior program enrollment documentation (if applicable)
- Current Physical
- Immunization Record
- Emergency Treatment Authorization
- Medication Policy
- Picture Policy and Permission

# St. Patrick's Preschool Agreement

This agreement is between St. Patrick's Preschool and the family of \_\_\_\_\_, beginning on \_\_\_\_\_ and ending on \_\_\_\_\_. \_\_\_\_\_ will attend the following class: (Please circle)

2 ½ year olds

Tuesday  
Thursday

3 year olds

Monday  
Wednesday  
Friday

4 year olds

Monday  
Tuesday  
Wednesday  
Thursday  
Friday

Optional extra days: (Please circle day(s) desired if applicable)

Monday      Tuesday      Wednesday      Thursday      Friday

The cost is \_\_\_\_\_ payable in advance on a weekly, biweekly, or monthly basis. Payments are due on the 1<sup>st</sup> of each month. I/We understand this contract may be amended at any time. A meeting will be held between St. Patrick's Preschool administration and the family to document changes. I/We understand and agree to the above statements.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

St. Patrick's Administrator: \_\_\_\_\_ Date: \_\_\_\_\_

## St. Patrick's Preschool

The 1998 General Assembly passed legislation to help identify missing children in child day care settings. In order to comply with this law, please send the following information within 7 days of initial attendance. Thank you very much for your cooperation in this matter.

Name of Student:

\_\_\_\_\_

Last	First	Middle
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Date of Birth: \_\_\_\_\_

Name of Last School Attended: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Parental Release:**

I hereby give my permission for the above information to be released to St. Patrick's Preschool.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

# St. Patrick's Preschool - Part I HEALTH INFORMATION FORM

Part I to be completed by parents of guardians of entering students. Ref. Code of Virginia 22.1-270.1

Student's Name \_\_\_\_\_  
Last First Middle

Student's Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Number of children in Family: \_\_\_\_\_

State or Country of Birth \_\_\_\_\_ Student's Social Security # \_\_\_\_\_ or  
ID# \_\_\_\_\_

Student's Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of School: \_\_\_\_\_ Grade: \_\_\_\_\_

Name of Mother or Legal Guardian: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name of Father or Legal Guardian: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

In case of emergency - if parent or guardian cannot be contacted - contact the following:

1. Name \_\_\_\_\_ Complete Phone Number: \_\_\_\_\_

2. Name \_\_\_\_\_ Complete Phone Number: \_\_\_\_\_

Birth History (weight, premature, and any other problems at birth): \_\_\_\_\_

**ALLERGIES** (food, medicine, insect bites, and any other allergies): \_\_\_\_\_

Chronic, Recurring, and Special Health Conditions (Check all that apply and explain below)

- \_\_\_\_\_ Arthritis (rheumatoid)
- \_\_\_\_\_ Asthma
- \_\_\_\_\_ Attention-Deficit/Hyperactivity Disorder
- \_\_\_\_\_ Behavioral or Developmental Problems
- \_\_\_\_\_ Cerebral Palsy
- \_\_\_\_\_ Cystic Fibrosis
- \_\_\_\_\_ Dental Problems
- \_\_\_\_\_ Encopresis (involuntary discharge of stool)
- \_\_\_\_\_ Enuresis (involuntary discharge of urine)
- \_\_\_\_\_ Head or Spinal injury
- \_\_\_\_\_ Hearing Impairment
- \_\_\_\_\_ Heart Disease
- \_\_\_\_\_ Kidney Disease
- \_\_\_\_\_ Muscular Dystrophy
- \_\_\_\_\_ Seizures
- \_\_\_\_\_ Sickle Cell Disease (not trait)
- \_\_\_\_\_ Spina Bifida
- \_\_\_\_\_ Visual Impairment
- \_\_\_\_\_ Other:

## Specialized Health Care Needed

List names of medical specialists or special clinics caring for your child: \_\_\_\_\_

Has your child ever been seen by a dentist? Yes \_\_\_\_\_ No \_\_\_\_\_. If yes, date of last appointment

Name of dentist: \_\_\_\_\_. List all prescription and over-the-counter medications  
taken regularly by your child: \_\_\_\_\_

Describe your child's operations and hospitalizations, if any (reason and date): \_\_\_\_\_

Describe any other important health-related information about your child: \_\_\_\_\_





**St. Patrick's Preschool**  
**PERMISSION FOR EMERGENCY CARE**

To be completed by parent/guardian at beginning of school year

Name of Student \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_  
Street City Zip

Student's Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Home Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Hours \_\_\_\_\_

Mother's Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Hours \_\_\_\_\_

Names(s) of Person(s) or Agency having legal custody\* \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Child's Allergies (if any)

Child's Doctor Phone

Outstanding medical history (ie: diabetes, heart disease, contact lenses, hearing aids, etc.)

Medication child is taking \_\_\_\_\_ Date of last tetanus shot \_\_\_\_\_

Insurance company \_\_\_\_\_ Policy Number \_\_\_\_\_

Persons NOT authorized to pick up child from school (\*if parent)

Emergency contacts: In the event a parent cannot be reached, please give name and phone number of two persons who could pick up and take home your child in a timely manner.

1. \_\_\_\_\_  
Name Relationship Phone

2. \_\_\_\_\_  
Name Relationship Phone

I agree to pick up my sick or injured child in a timely manner when contacted. If I cannot be reached, the above emergency contacts can be called to pick up my child. Additionally, if I cannot be contacted in an emergency, the school has my permission to take my child to the emergency room of the nearest hospital and I hereby authorize its medical staff to provide treatment which a physician deems necessary for the well-being of my child.

\*Appropriate custody paperwork must be attached.

# St. Patrick's Preschool Medication Policy

St. Patrick's staff will not administer over the counter medication to students.

St. Patrick's will administer prescription medication if the scheduled time for that medication falls during school hours. Whenever possible, medication should be given prior to or after school. Written authorization from the child's physician and parents is required before medication can be administered.

If the physician and parents request that medication be given, the following rules apply:

1. The medication authorization shall be available to staff during the entire time it is in effect.
2. Medications shall be labeled with the child's name, the name of the medication, the dosage amount and the times to be given.
3. Medications shall be in the original container with the prescription label or directions attached.
4. When needed, medications shall be refrigerated. Medications must be stored separately from food.
5. Medications will be stored in a locked place which is inaccessible to children.
6. A medication record of administration will be kept and signed by two staff members to assure proper administration.
7. The record of medication administration shall include the following:
  - A. Name of child receiving medication.
  - B. Amount and type of medication administered.
  - C. Signature of staff member distributing medication and signature of one other staff member as a witness.
  - D. Description of any adverse reaction.
  - E. Description of any medication or administration error.
8. Parents shall be informed immediately of any adverse reaction to medication or any error in administration.
9. Medication shall be returned to the parents as soon as the medication is no longer being administered.

**St. Patrick's Preschool  
Day Care Medication Permission Sheet**

Child's Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Name of Provider: \_\_\_\_\_  
Name of Medication: \_\_\_\_\_  
Condition for which prescribed: \_\_\_\_\_  
Possible side effects: \_\_\_\_\_

**INSTRUCTIONS:**

Dosage Amount: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
Times of day to be administered: \_\_\_\_\_  
Date: \_\_\_\_\_ Signature \_\_\_\_\_  
Parent

Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

**IF PRESCRIPTION:**

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_ RX NO: \_\_\_\_\_

Fill in date, time and initials whenever medication is dispensed

Monday      Tuesday      Wednesday      Thursday      Friday

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

Medication was returned to parents: \_\_\_\_\_  
or Medication was disposed of: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_

# St. Patrick's Preschool Photo Release Form

I, being the parent/guardian of \_\_\_\_\_ hereby consent that the videotape, photograph, motion picture film in which the above child may appear, and/or audio recording of said child's voice may be used by St. Patrick's Preschool, their assigns or successors, in whatever way they desire.

Furthermore, I hereby consent that such photographs, films, recordings, and the plates and/or tapes from which they are made shall be their property, and they shall have the right to sell, duplicate, reproduce, and make other uses of such photographs, films recordings, plates and tapes as they may desire free and clear of any claim whatsoever on my part.

In witness whereof I have hereunto set my hand, in the state of Virginia, on the date of: \_\_\_\_\_

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

Parent/Guardian: \_\_\_\_\_  
Signature

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_