ST. BERNARD ACADEMY

Three-Year-Old Program 2020–2021
Enrollment Application

I. CHILD INFORMATION

NAME: _____

MALE ☐ FEMALE ☐ DATE OF BIRTH: _____

ADDRESS LINE 1: _____

ADDRESS LINE 2: _____

CITY: _____ STATE: _____ ZIP: _____

IS YOUR CHILD ADOPTED? YES ☐ NO ☐

IF SO, DOES THE CHILD KNOW? YES ☐ NO ☐

IS A LANGUAGE OTHER THAN ENGLISH SPOKEN AT HOME? YES ☐ NO ☐

IF NO, WHAT LANGUAGE(S)? _____

AT WHAT AGE DID YOUR CHILD ACCOMPLISH EACH OF THE FOLLOWING:

CREPT ON HANDS AND KNEES: _____ SAT ALONE: _____

NAMED SIMPLE OBJECTS: _____ REPEATED SHORT SENTENCES: _____

BEGAN TOILET TRAINING: _____

WHAT ARE YOUR CHILD'S FAVORITE FOODS: _____

_____

DOES YOUR CHILD DISLIKE ANY FOODS? IF SO, PLEASE SPECIFY: _____

_____

WHAT TIME(S) DOES YOUR CHILD TAKE A NAP: _____

DOES YOUR CHILD HAVE ANY SPECIAL NAP REQUIREMENTS: _____

_____

IS YOUR CHILD TOILET TRAINED? YES ☐ NO ☐ IF YES, HOW LONG / DATE: _____

HOW DOES YOUR CHILD INDICATE THAT HE OR SHE NEEDS TO USE THE RESTROOM? _____

_____

CAN YOUR CHILD DRESS HIM OR HERSELF? YES ☐ NO ☐

IS YOUR CHILD RIGHT OR LEFT HANDED? RIGHT ☐ LEFT ☐

DOES YOUR CHILD SLEEP WELL? YES ☐ NO ☐

FAVORITE INDOOR PLAY ACTIVITIES: _____

_____

_____

FAVORITE OUTDOOR ACTIVITIES: _____

_____

DOES YOUR CHILD HAVE ANY FEARS YOU ARE AWARE OF? IF SO, WHAT ARE THEY? _____

_____

DOES YOUR CHILD HAVE ANY SPEECH, SIGHT, OR HEARING PROBLEMS? IF SO, WHAT ARE THEY? _____

_____

HAS YOUR CHILD ATTENDED SCHOOL, PRESCHOOL, OR DAYCARE BEFORE? IF SO, WHERE AND HOW LONG? _____

_____

WHAT IS YOUR DISCIPLINARY METHOD USED AT HOME? _____

_____

WHAT IS YOUR CHILD'S USUAL REACTION? _____

_____

DESCRIBE YOUR CHILD'S PERSONALITY: _____

_____

WHAT IS YOUR CHILD'S ACTIVITY LEVEL? _____

_____

IS YOUR CHILD READ TO REGULARLY? YES ☐ NO ☐

WHAT IS HIS OR HER FAVORITE BOOK OR STORY? _____

_____

IS YOUR CHILD INTERESTED IN MUSIC? IF SO, WHAT IS YOUR CHILD'S FAVORITE SONG OR MUSICIAN? _____

_____

DOES YOUR CHILD ENJOY ARTS AND CRAFTS? IF SO, WHAT IS YOUR CHILD'S FAVORITE ARTISTIC MEDIUM (E.G., CRAYONS, CLAY, ETC.)? _____

_____

DOES YOUR CHILD GET ALONG WELL WITH OTHER CHILDREN? YES ☐ NO ☐

DOES YOUR CHILD ACCEPT NEW PEOPLE EASILY? YES ☐ NO ☐

DOES YOUR CHILD HAVE ANY NERVOUS HABITS? IF SO, WHEN ARE THEY LIKELY TO SHOW? _____

_____

DOES YOUR CHILD NEED SPECIAL HELP WITH ANYTHING? IF SO, PLEASE EXPLAIN: _____

_____

IS THERE ANY INFORMATION YOU WOULD LIKE TO SHARE ABOUT YOUR CHILD? _____

_____

_____

II. PARENT INFORMATION

PARENT ONE NAME: _____ SSN: _____

ADDRESS LINE 1: _____

ADDRESS LINE 2: _____

CITY: _____ STATE: _____ ZIP: _____

BUSINESS ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ BUSINESS PHONE: _____

MOBILE PHONE: _____ EMAIL: _____

WOULD YOU LIKE TO RECEIVE TEXT MESSAGES? YES ☐ NO ☐

WORK SCHEDULE:

MONDAY: _____ TO _____

TUESDAY: _____ TO _____

WEDNESDAY: _____ TO _____

THURSDAY: _____ TO _____

FRIDAY: _____ TO _____

PARENT TWO NAME: _____ SSN: _____

ADDRESS LINE 1: _____

ADDRESS LINE 2: _____

CITY: _____ STATE: _____ ZIP: _____

BUSINESS ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ BUSINESS PHONE: _____

MOBILE PHONE: _____ EMAIL: _____

WOULD YOU LIKE TO RECEIVE TEXT MESSAGES? YES ☐ NO ☐

WORK SCHEDULE:

MONDAY: _____ TO _____

TUESDAY: _____ TO _____

WEDNESDAY: _____ TO _____

THURSDAY: _____ TO _____

FRIDAY: _____ TO _____

III. FAMILY INFORMATION

PARENTS' MARITAL STATUS: _____

IF SEPARATED OR DIVORCED, WHO HAS PRIMARY LEGAL CUSTODY? _____

IF SEPARATED OR DIVORCED, WHO IS THE PRIMARY RESIDENTIAL PARENT? _____

If separated or divorced, please attach a copy of the parenting plan (or similar court document if from court outside Tennessee.)

DOES EITHER PARENT HAVE AN INTERESTING OCCUPATION, HOBBY, OR TALENT? _____

_____

ARE THERE ANY OTHER FAMILY MEMBERS IN YOUR HOUSEHOLD? YES ☐ NO ☐

IF SO, PLEASE LIST EACH FAMILY MEMBER AND HIS OR HER RELATIONSHIP TO YOUR CHILD?

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: ______________________ RELATIONSHIP: ______________________

NAME: ______________________ RELATIONSHIP: ______________________

NAME: ______________________ RELATIONSHIP: ______________________

NAME: ______________________ RELATIONSHIP: ______________________

IS THERE ANY OTHER INFORMATION ABOUT YOUR FAMILY THAT YOU WOULD LIKE TO SHARE? ______________________

IV. EMERGENCY CONTACT INFORMATION

Please list persons whom you would like us to contact in the event of an emergency if neither parent can be reached.

NAME: ______________________ RELATIONSHIP TO CHILD: ______________________

ADDRESS LINE 1: ______________________

ADDRESS LINE 2: ______________________

CITY: ______________________ STATE: __________ ZIP: __________

BUSINESS ADDRESS: ______________________

CITY: ______________________ STATE: __________ ZIP: __________

HOME PHONE: ______________________ BUSINESS PHONE: ______________________

MOBILE PHONE: ______________________ EMAIL: ______________________

WOULD YOU LIKE TO RECEIVE TEXT MESSAGES? YES ☐ NO ☐

NAME: ______________________ RELATIONSHIP TO CHILD: ______________________

ADDRESS LINE 1: ______________________

ADDRESS LINE 2: ______________________

CITY: ______________________ STATE: __________ ZIP: __________

BUSINESS ADDRESS: ______________________

CITY: ______________________ STATE: __________ ZIP: __________

HOME PHONE: ______________________ BUSINESS PHONE: ______________________

MOBILE PHONE: ______________________ EMAIL: ______________________

WOULD YOU LIKE TO RECEIVE TEXT MESSAGES? YES ☐ NO ☐

NAME: ______________________ RELATIONSHIP TO CHILD: ______________________

ADDRESS LINE 1: ______________________

ADDRESS LINE 2: ______________________

CITY: ______________________ STATE: __________ ZIP: __________

BUSINESS ADDRESS: ______________________

CITY: ______________________ STATE: __________ ZIP: __________

HOME PHONE: ______________________ BUSINESS PHONE: ______________________

MOBILE PHONE: ______________________ EMAIL: ______________________

WOULD YOU LIKE TO RECEIVE TEXT MESSAGES? YES ☐ NO ☐

MEDICAL INFORMATION SHEET

CHILD'S NAME (LAST, FIRST): _____ CHILD'S DATE OF BIRTH: _____

PHYSICIAN'S NAME: _____ PHYSICIAN'S PHONE NUMBER: _____

PHYSICIAN'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

INSURANCE COMPANY: _____ POLICY NUMBER(S): _____

PREFERRED HOSPITAL: _____ CHILD'S BLOOD TYPE: _____

PLEASE LIST ANY MEDICINE ALLERGIES: _____

_____

_____

PLEASE LIST ANY SPECIAL MEDICAL CONDITIONS: _____

_____

_____

PLEASE PLACE A CHECK IN THE BOX IF YOUR CHILD HAS OR PREVIOUSLY HAD ANY OF THE FOLLOWING CONDITIONS:

☐	ASTHMA	☐	CHICKEN POX	☐	CONSTIPATION
☐	CONVULSIONS	☐	DIABETES	☐	EAR INFECTIONS
☐	FAINTING SPELLS	☐	FREQUENT COLDS	☐	FREQUENT SORE THROAT
☐	HEART ATTACK	☐	GERMAN MEASLES	☐	HEPATITIS
☐	HIV/AIDS	☐	IMPETIGO	☐	LICE
☐	MEASLES	☐	MUMPS	☐	POLIO
☐	RINGWORM	☐	SCARLET FEVER	☐	SKIN RASH
☐	TUBERCULOSIS	☐	UPSET STOMACH	☐	URINARY PROBLEMS
☐	WHOOPING COUGH	☐	OTHER: _____		

DIETARY RESTRICTIONS FORM

CHILD'S NAME (LAST, FIRST): ____________________

PLEASE LIST ANY DIETARY RESTRICTIONS FOR YOUR CHILD BELOW.

RESTRICTED FOOD OR FOOD GROUP: ____________________

____

ACCEPTABLE ALTERNATIVES (E.G., MILK RESTRICTION, SOY MILK SUBSTITUTE): ____________________

____

IF RESTRICTION IS DUE TO A FOOD ALLERGY, PLEASE DESCRIBE YOUR CHILD'S REACTION: ____________________

____

RESTRICTED FOOD OR FOOD GROUP: ____________________

____

ACCEPTABLE ALTERNATIVES (E.G., MILK RESTRICTION, SOY MILK SUBSTITUTE): ____________________

____

IF RESTRICTION IS DUE TO A FOOD ALLERGY, PLEASE DESCRIBE YOUR CHILD'S REACTION: ____________________

____

RESTRICTED FOOD OR FOOD GROUP: ____________________

____

ACCEPTABLE ALTERNATIVES (E.G., MILK RESTRICTION, SOY MILK SUBSTITUTE): ____________________

____

IF RESTRICTION IS DUE TO A FOOD ALLERGY, PLEASE DESCRIBE YOUR CHILD'S REACTION: ____________________

____

RESTRICTED FOOD OR FOOD GROUP: ____________________

____

ACCEPTABLE ALTERNATIVES (E.G., MILK RESTRICTION, SOY MILK SUBSTITUTE): ____________________

____

IF RESTRICTION IS DUE TO A FOOD ALLERGY, PLEASE DESCRIBE YOUR CHILD'S REACTION: ____________________

____

RESTRICTED FOOD OR FOOD GROUP: ____________________

____

ACCEPTABLE ALTERNATIVES (E.G., MILK RESTRICTION, SOY MILK SUBSTITUTE): ____________________

____

IF RESTRICTION IS DUE TO A FOOD ALLERGY, PLEASE DESCRIBE YOUR CHILD'S REACTION: ____________________

____

EMERGENCY RELEASE

CONSENT TO EMERGENCY FIRST AID AND TRANSPORTATION

I hereby give permission for my child, _____
to be given emergency treatment by a staff member of St. Bernard Academy. I also give permission for my child to be transported by car, ambulance, or aid vehicle to an emergency center for treatment and agree to hold St. Bernard Academy and its employees harmless for any injury resulting from such measures.

PARENT SIGNATURE: _____ DATE: _____
PARENT SIGNATURE: _____ DATE: _____

CONSENT TO MEDICAL CARE AND TREATMENT

In the event that I cannot be contacted immediately, medical or surgical treatment may be administered to my child in the case of an accident or emergency as prescribed by a treating physician. I agree to hold St. Bernard Academy harmless for such measures.

PARENT SIGNATURE: _____ DATE: _____
PARENT SIGNATURE: _____ DATE: _____

WAIVER OF CLAIMS

I agree that neither or nor my child will bring any claims of any kind against St. Bernard Academy and its employees as a result of injuries, expenses, or damages that I or my child may suffer in any way related to the use of St. Bernard Academy facilities, toys, other children, teachers, or the like. This waiver applies to all claims, whether known or unknown, present or future. St. Bernard Academy shall not be responsible for providing or paying for my child's health care.

PARENT SIGNATURE: _____ DATE: _____
PARENT SIGNATURE: _____ DATE: _____

PERSONS AUTHORIZED TO PICK UP

_____
_____
_____
_____
_____

PERSONS NOT AUTHORIZED TO PICK UP

_____
_____
_____
_____
_____