Holy Cross ACADEMY

Preschool Program Enrollment

CAMPUS LOCATION

_____ Our Lady of Providence Campus: 3-5 year olds
_____ St. Dominic Savio: 2-5 year olds
_____ St. Michael the Archangel Campus: 2-5 year olds

Fax: 314-270-8233

CHILD/FAMILY INFORMATION

Child's Name: _____
(last) (first) (M.I.) (nickname)

Date of Birth: _____/_____/_____ Gender: M / F Allergies/Medical Conditions: _____

Parent/Guardian:

Name: _____
Home Address: _____
_____
City: _____Zip Code:_____
Home phone: _____
Work phone: _____
Cell phone: _____
Email: _____
Occupation: _____
Employer: _____

Parent/Guardian:

Name: _____
Home Address: _____
_____
City: _____Zip Code: _____
Home phone: _____
Work phone: _____
Cell phone: _____
Email: _____
Occupation: _____
Employer: _____

Child Lives with: Both Parents / Mother / Father / Guardian / Dual Custody:_____

**Dual Custody or Divorced families need to provide a copy of the custody agreement at time of enrollment.

Current Parish/Church Affiliation: _____

Parish and Date of Baptism: _____

Public School District in which you live: _____

Sibling(s):

Name: _____ Age: _____ School: _____Grade: _____
Name: _____ Age: _____ School: _____Grade: _____
Name: _____ Age: _____ School: _____Grade: _____

Has attended a preschool or a Mom's Day out? _____ YES _____ NO If yes, where? _____

My child likes to: _____

My goal for my child this year: _____

_____

Other comments you want to share about your child: _____

_____

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NON-PARENT EMERGENCY CONTACTS

**Contacts listed below will also have permission to pick-up child from school

Name: _____ Relationship to Child: _____

Home phone: _____ Work phone: _____ Cell phone: _____

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Home phone: _____ Work phone: _____ Cell phone: _____

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Home phone: _____ Work phone: _____ Cell phone: _____

Other people/carpool who are authorized to pick-up child from preschool:

Name: _____ Phone: _____

Name: _____ Phone: _____

MEDICAL RELEASE

I understand that basic first aid will be given to my child at school for minor incidents. If an emergency requiring additional medical care is needed, I hereby authorize preschool staff members to take my child to a local hospital and/or call an ambulance, if I can't be contacted.

Physician's Name: _____ Clinic: _____

Address: _____ Phone: _____

For emergency medical treatment my preferred hospital is: _____

Hospital Phone: _____

All Holy Cross Preschool Programs offer the same goals and curriculum, but with different classroom experiences at each location. Our programs will provide children with a foundation socially, emotionally, spiritually and educationally.

I understand that each Holy Cross preschool program offers a variety of developmentally appropriate experiences, learning opportunities and engaging environments for my child.

Parent/Guardian Signature: _____ Date: _____

A copy of immunizations and the preschool health form will need to be returned by June 1