

CHILD APPLICATION (\$20 application fee due when turned in) Date: _____

(Please Print Legibly)

HOLY SPIRIT PRESCHOOL

3930 Parish Ave.
Fremont, CA 94536
hs.preschool@sbcglobal.net

_____ Catholic ____ Non-Catholic ____
Family Name (Last name) _____ Child's Date of Birth _____
_____ Male ___ Female

Child's Name (Last) (First) (Middle)

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

E-Mail Address _____

Has your child attended preschool / daycare previously? Y or N If so, list below (more than 1, list on back):

School/Daycare _____ City _____ Phone _____ How long? _____
=====

Other Siblings (Name & Date of birth) _____

Siblings at Holy Spirit Elementary (Currently or previously) ____Y ____N If yes, what grade? _____

Father _____
Last Name _____ First Name _____ Place of Birth _____ Religion _____
Y ___ N ___

Occupation _____ Employer _____ Business Phone _____ U.S. Citizen _____

Mother _____
Last Name _____ First Name _____ Place of Birth _____ Religion _____
Y ___ N ___

Occupation _____ Employer _____ Business Phone _____ U.S. Citizen _____

Check all home conditions that apply:

Traditional ____ Divorced ____ Father Deceased ____ Mother Deceased ____ Foster Home ____ Mixed Religion ____
Father Separated ____ Father Remarried ____ Mother Separated ____ Mother Remarried ____

Child lives with: Both Parents ____ Grandparents ____ Mother ____ Father ____ Guardian ____ Other ____

Race (Optional) Asian ____ Black/African American ____ Hispanic ____ Native American/Alaskan ____
Pacific Islander/Native Hawaiian ____ White / Caucasian ____ Other ____

Are you registered at your Parish: Yes ____ No ____

Name of your parish _____ Envelope # _____

For which session are you applying: (All programs are Monday – Friday)

Note: 3's prgm: born Dec. 2005 – Aug. 2006 & 4's prgm: born Dec, 2004 – Nov. 2005

Full Day 3's ____ 4's ____

Are you interested in our Summer Program? Yes No (if you're applying for 3's, your child must be 3 by this time and fully potty trained).

Do you intend to send your child to Holy Spirit Elementary? Y / N (No guarantees, separate enrollment)

Are you willing to volunteer a minimum of 5 hours per school year? Yes No

For Office use only:

Date _____ App. Fee Pd. on _____ Reg. Fee Pd. on _____ Start Date _____

**HOLY SPIRIT PRESCHOOL
PRE-ADMISSION HEALTH/DEVELOPMENT HISTORY - PARENT'S REPORT**

Name _____ Birthdate _____

Indicate age your child: walked unassisted _____ spoke words _____ spoke in sentences _____

Reason for requesting Preschool placement _____

Would you be able to volunteer in the classroom (5 mandatory hours per school year)? _____

Sleeping Habits

- What time does your child get up in the morning? _____ Go to bed? _____

- Does your child nap in the afternoon? _____ Does your child have frequent nightmares? _____

Toilet Habits

- Is your child fully potty trained? _____ Does your child wear Pull-Ups? _____

- What words does your child say for Urination _____ Bowel Movement _____

- Does your child have a history of Bladder infections _____ Diarrhea or Constipation _____

Does your child suck his/her thumb during the day or have other pacifying routines? _____

Social Setting

Tell us something special about your child. _____

Briefly describe your child's relationship with his/her brothers and sisters _____

Group play experience (if any) _____

Are there other adults living in the home besides the parents? _____

Does your child have problems in being separated from you? _____

If your child is adopted, does he/she know it? _____

What do you consider to be your child's strengths and weaknesses? _____

What skills and/or experience do you feel are important for your child to receive in preschool? _____

What discipline techniques do you use at home with your child? _____

Does your child eat independently? _____

Do you feel that your son/daughter has any special problems/fears of adjustment to friends, to school or to family that should be brought to the attention of your physician or school personnel? Y / N

Comments: _____

COMPLETE OTHER SIDE

Language

What is your child’s primary language spoken in the home? _____

Does your child speak more than one (1) language fluently? Y / N.

If yes, what language(s)? _____

Medical History to be completed by Parent

Health History (check the conditions where appropriate)

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergy to Medications | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Freq. Leg or Joint Pain | <input type="checkbox"/> Rubella (3 day measles) |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hernia (Rupture) | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Speech Difficulty |
| <input type="checkbox"/> Defective Vision | <input type="checkbox"/> Lameness | <input type="checkbox"/> Teeth Problems |
| <input type="checkbox"/> Wears Glasses | <input type="checkbox"/> Measles (Rubeola) | <input type="checkbox"/> Tires Easily |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Dizziness/blackouts | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Ear Trouble | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Poliomyelitis | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Recurrent Boils | <input type="checkbox"/> Allergy to Foods (List Below) |
| <input type="checkbox"/> *Other (Please explain in the space below) | | |

*Other medical conditions not listed above (birth defects/marks, ear/eye conditions, etc): _____

Does child have frequent colds? Y / N Approximately how many in last year? _____

List any other serious illness, operation or injury and the age when this happened.

List all foods/substances/medications your child is allergic to (be specific): _____

Has your son or daughter had contact with and / or had tuberculosis? Y / N Last contact _____

Has your child ever been advised not to participate in physical activity? Y / N

Is your child now under care for any medical problem? Y / N If so, please specify _____

Does your child take any medication/vitamin/supplement on an ongoing daily basis? Y / N If yes, please explain

What is the plan for your child when he/she becomes ill at school and who should we contact first?

Parent’s Signature: _____ Date: _____