

Hawley Elementary School
Preschool Enrollment Form
2022-2023

STUDENT INFORMATION:

Child's Name: _____ Gender ___ Age ___ Birth Date _____
(Last) (First) (Middle)

Home Address _____ Mailing Address _____

Father/Guardian Name _____ Cell # _____

Mother/Guardian Name _____ Cell # _____

Fathers Work Phone _____ Mothers Work Phone _____

Fathers Work Place _____ Mothers Work Place _____

Fathers Email _____ Mothers Email _____

LIVING WITH:

___ Mother/Father Same Household ___ Father ___ Mother ___ Guardian ___ Step Parent Name _____

In most cases, divorced parents continue to have equal rights, such as access to information, where their children are concerned. If you have a court order that limits the rights of one parent in matters such as custody or visitation, please bring a copy to the school office. Unless your court order is on file with us, we must provide equal rights and access to both natural parents.

NON-CUSTODIAL PARENT _____ Phone _____

Address _____

DAY CARE PROVIDER:

Name _____ Address _____ Phone _____

I, _____, give permission for my child to participate in any field trips.
(parent)

I, _____, give permission to have any picture taken of my child to be used in the
(parent)
newspaper, displays, slide presentations and/or media publications.

Please enroll my child in the following session:

- _____ 8:00 - 2:45 Monday and Wednesday (Four-Five Year Olds) \$150 Monthly Fee
- _____ 8:00 - 2:45 Tuesday and Thursday (Four-Five Year Olds) \$150 Monthly Fee
- _____ 8:00 - 11:00 Friday (Three Year Olds) \$60 Monthly Fee

_____ **I understand that my deposit for September's tuition WILL NOT be refundable.**

SIGNATURE OF PARENT(S)/GUARDIAN(S): If there are two parents/guardians at the home, both are required to sign the form.

(signature of father/guardian)

(signature of mother/guardian)

OVER - PLEASE FILL OUT BACK SIDE

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EMERGENCY PERSON TO CONTACT IF PARENT CANNOT BE REACHED:
(OTHER THAN YOUR CHILD)

Name _____ Relationship _____ Home Phone _____

City _____ Work Phone _____ Cell Phone _____

Physician's Name _____ Clinic/Hospital _____ Phone _____

Dentist's Name _____ Phone _____

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DOES YOUR CHILD HAVE ANY CONCERNS WITH:

- | | |
|--|----------------|
| Allergies: (food, environmental, insect bites, medications, etc) | ___ yes ___ no |
| Vision: (vision loss, glasses, contacts, eye surgery, etc.) | ___ yes ___ no |
| Hearing: (ear infections, tubes, surgery, hearing loss, etc.) | ___ yes ___ no |
| Speech & Language Problems: | ___ yes ___ no |
| Nutrition & Dietary Concerns: (special diet, allergy, etc.) | ___ yes ___ no |
| Metabolic: (diabetes, etc.) | ___ yes ___ no |
| Elimination: (bowel, bladder, kidney, etc.) | ___ yes ___ no |
| Neurological: (epilepsy, seizures, cerebral palsy, spina bifida, etc.) | ___ yes ___ no |
| Respiratory: (asthma, pneumonia, bronchitis, etc.) | ___ yes ___ no |
| Skin: (eczema, dermatitis, etc.) | ___ yes ___ no |
| Cardiac: (congenital heart disease, etc.) | ___ yes ___ no |
| Coping & Emotional: (depression, recent loss, anxiety, fear, pain) | ___ yes ___ no |
| Attention Deficit/Hyperactivity, Oppositional Disorder: | ___ yes ___ no |
| Physical: (limitations for phy-ed or contact sports) | ___ yes ___ no |
| Orthopedics: (braces, prosthesis, wheelchair, etc.) | ___ yes ___ no |
| Cancer: | ___ yes ___ no |
| Other: | ___ yes ___ no |

If you answered yes to any of the above questions, please use the space provided to explain:

I authorize the following to pick up my child from the preschool program:

_____	_____
_____	_____
_____	_____
_____	_____

OVER – PLEASE FILL OUT FRONT SIDE