Mason High School Laboratory Preschool Application

Attention: Deb Schafer
1001 S. Barnes St. Mason, MI 48854
(517) 676-9055 ext. 222

Child's Name: ___________________________________

Nickname for use in school _________________ Date of Birth: __________________

Address: ______________________________ City/ Zip Code: _________________

Mother's Name: _________________________ Email _______________________

Address (if different from the child): _______________________________________

Home Phone: ______________________ Work or Cell Phone: __________________

Father's Name: _________________________ Email _______________________

Address (if different from the child): _______________________________________

Home Phone: ______________________ Work or Cell Phone: __________________

Please list siblings and ages ____

____

Child is Living With (please circle appropriate choice):

Both Parents Mother Father Guardian

Mother/Stepfather Father/Stepmother Other: __________________

To whom may your child be released at the conclusion of the preschool each day? If anyone other than the parents listed above or the people listed here attempt to pick up your child, your child will remain at the preschool and you will be contacted.

_____________________________ ________________________________

_____________________________ ________________________________

Please list any activities your child particularly likes:

____

Is there any additional information about your child you would like us to know?

____

____

Emergency Information

In the event of an emergency and the parent(s) cannot be reached, who would you like notified?

Name ______________________________ Relationship to Child ______________

Home Phone: _________________________ Work or Cell Phone: ______________

I authorize Mason High School Laboratory preschool staff to seek medical attention for my child if an emergency occurs:

____ ____________________

Parent/Guardian Signature Date

Health & Medical Information

Is you child experiencing any of the problems listed below?	**YES**	**NO**
1. Allergies or reactions. For example food, medication, etc.	_____	_____
2. Hay fever, asthma, wheezing	_____	_____
3. Eczema or frequent skin rash	_____	_____
4. Convulsions/seizures	_____	_____
5. Heart trouble	_____	_____
6. Diabetes	_____	_____
7. Frequent colds, sore throats, earaches (4 or more per year)	_____	_____
8. Trouble passing urine or bowel movements	_____	_____
9. Shortness of Breath	_____	_____
10. Speech problems	_____	_____
11. Dental problems	_____	_____
12. Other ____	_____	_____

Please explain any problem identified above: ____________________________________

____

Does your child take medication regularly? YES _________ NO __________

If yes, what medication? ____

Is there any problem in vision, hearing, or other condition that the Mason High School Laboratory preschool needs to be aware of?

YES _______ NO _________ If yes, please explain: ________________________

____

Immunizations

Please fill in this form **or** attach a copy of your child's immunization record.

VACCINE	DATE ADMINISTERED	
Diptheria Tetanus Pertussis	1.	6.
	2.	7.
	3.	8.
	4.	9.
	5.	10.
H. Influenzae B	1.	3.
	2.	4.
Polio	1.	3.
	2.	4.
Measles Mumps Rubella	1.	
	2.	
Hepatitis B	1.	3.
	2.	
Varicella (Chicken Pox)		
Other Vaccines		
Vaccines have been waived due to reactions, contraindications or religious objections.	______________________ Parent/Guardian Signature	

I certify that the immunizations listed above are true to the best of my knowledge.

________________________________ ________________

Parent/Guardian Signature Date