



KIDS ADVENTURE PRESCHOOL

2018-2019 Registration Form

810 2nd Avenue SW - Door #2, Perham, MN 56573
(218)346-1618

LAST NAME: _____

Admin use only:

Date received: _____ by: _____

Reduced lunch form complete: _____

Qualify: F R

2-Day 4-Day

Funding Source: 01 02 04 05 11 12

Immunizations: UTD Exemption Need

Child's Full Legal Name: _____ Date of Birth: _____ Child's Sex: F M

Mother's Name: _____ Mother's Address: _____

Father's Name: _____ Father's Address (if different): _____

Mother's Employer: _____ Father's Employer: _____

Parent Contact Email Address: _____

Child Resides With: Mother _____ Father _____ Both _____ Other: _____

Address (if other): _____

Phone Number(s):

Mother's Home: _____ work: _____ cell: _____

Father's Home: _____ work: _____ cell: _____

Date of Preschool screening: _____ Child's age as of September 1: _____ Number in household _____

Child's resident school district: _____ Perham ISD 549 _____ Other (please indicate) _____

Please Check One: 3-Year-Old Program _____ 4-Year-Old Program _____ 4/5 Year-Old Program _____

Which session would you like to see your child enrolled: (please rank first and second choice)

Classes will be offered as long as we can fill the spots.

_____ 3-year old program (Mon. & Wed. am)

_____ 4/5 year old program (2 Full days Mon and Wed)

_____ 3-year old program (Mon. & Wed. pm)

_____ 4/5 year old program (2 Full days Tue and Thursday)

_____ 3-year old program (Tues. & Thurs. am)

_____ 4/5 year old program (Mon. thru Thur. all day)

_____ 3-year old program (Tues. & Thurs. pm)

_____ 3-year old program (Mon. thru Thurs. am)

_____ 3-year old program (Mon. thru Thurs. pm)

Photograph/Video Consent: I give permission to Kid's Adventure & ISD #549 Staff to record images of my child (please circle) YES NO

Primary Language spoken in your home _____ The race/ethnicity of child _____

Request to send newsletters or progress reports to parent living outside of home:

Name: _____ Address: _____

Parent/Guardian Signature: _____ Date: _____

(I certify that all of the information provided is true and accurate. I understand this information is being given for the receipt of state funds, and school officials may verify the information on this application.)

(Please continue on reverse side)

Medical History (Please fill in every blank or write N/A where appropriate)

Allergies: Drug _____ Food _____
 Special Medical/Mental Diagnosis _____
 Heart Condition _____ Asthma _____ Seizures _____ Diabetes _____
 Recent Illness or Surgery _____
 Physical Disabilities _____
 Childhood Diseases _____
 Medications your child is taking _____
 Name of Child's Medical Insurance Company _____
 Child's MA # _____ MNCare # _____ Insurance # _____
 Child's Family Physician _____ Phone # _____
 Complete Address _____
 Suggested Hospital _____ Phone # _____
 Complete Address _____
 Child's Family Dentist _____ Phone # _____
 Complete Address _____
 Is your child on an IEP (Individual Educational Plan)? _____

Census Information: Please list name and birth date of any other children living in your household

Name	Date of Birth	Gender	Grade (if attending)	Relationship to Student

Parent/Guardian contact is critical in an emergency. We make every effort to contact you or one of the emergency contacts listed below. Your child will only be released to parents/guardian listed above or the persons listed below.

NAME	ADDRESS	DAYTIME PHONE #	CELL#	RELATIONSHIP
1.) _____	_____	_____	_____	_____
2.) _____	_____	_____	_____	_____
3.) _____	_____	_____	_____	_____

If your child's daycare provider is not one of the contacts listed above, please provide the following information:

Child's Daycare Provider Contact Information _____ Phone # _____

*I, THE UNDERSIGNED PARENT OR GUARDIAN, HEREBY GIVE MY CONSENT, IN THE EVENT OF AN EMERGENCY WHERE NEITHER MY FAMILY PHYSICIAN NOR I CAN BE CONTACTED, FOR THE ABOVE-NAMED CHILD TO BE TAKEN BY **KIDS ADVENTURE STAFF** TO THE NEAREST APPROPRIATE FACILITY FOR ALL NECESSARY MEDICAL CARE AS RECOMMENDED BY THE ATTENDING PHYSICIAN/DENTIST.*

*I ACCEPT RESPONSIBILITY FOR ANY COSTS ARISING FROM SUCH TREATMENT THAT ARE NOT COVERED BY INSURANCE AND/OR MEDICAL ASSISTANCE. I HEREBY CONSENT TO HAVING A CONTACT CARD AVAILABLE IN THE CLASSROOM, ON THE CHILD'S BUS, AND IN THE **KIDS ADVENTURE** OFFICE.*

SIGNATURE OF PARENT/GUARDIAN

DATE

SIGNATURE OF STAFF

DATE