2019-2020 Registration Form

810 2nd Avenue Southwest, 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)
_____ 3-year old program (Mon. & Wed. pm)
_____ 3-year old program (Tues. & Thurs. am)
_____ 3-year old program (Tues. & Thurs. pm)
_____ 3-year old program (Mon. thru Thurs. am)
_____ 3-year old program (Mon. thru Thurs. pm)

_____ 4/5 year old program (2 Full days Mon and Wed)
_____ 4/5 year old program (2 Full days Tue and Thursday)
_____ 4/5 year old program (Mon. thru Thur. all day)

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 APPROPIATE 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