



KIDS ADVENTURE PRESCHOOL

2020-2021 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: _____
_____ Child's Sex: F M

Date of Birth: _____

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)

Page 2

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
DATE

SIGNATURE OF STAFF